The Analysis of the Provider, Payer, and Regulator Stakeholders' Understanding and Acceptance of the Universal Healthcare Law in Three Provinces in the Philippines: A Qualitative Study Using a Content Analysis Approach

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ABSTRACT

Background and Objective. In 2018, the Philippine Congress passed the Universal Healthcare (UHC) Law and its implementing rules which mandated the enrollment of all Filipinos to PhilHealth, the national social health insurance corporation. The Department of Health (DOH) and PhilHealth will leverage their strategic purchasing power by affiliating Health Care Provider Networks (HCPNs), established within the geopolitical boundaries of a province or a highly urbanized city, through service level agreements. This study aims to shed light on what is expected from providers, payers, and regulators to implement UHC successfully.

Methods. The researchers conducted an inductive, content analytic qualitative study guided by the World Health Organization's (WHO) Building Blocks Framework to determine the understanding and acceptance of the implementing rules of the UHC Law and the perceived barriers and enablers from the provider, payer, and regulator stakeholders in three provinces in the Philippines. Purposive sampling was utilized to provide the best representation across different economic and physical settings. A content analysis was done through an inductive process of coding concepts, which was the basis for categories grouped and matched deductively with the WHO framework. This formed the broader sub-themes and were used for the final data interpretation.

Results. A total of 16 focus group discussions (FGDs) and nine in-depth interviews (IDIs) were performed with 84 participants. Inductive thematic analysis of categories and subcategories showed that the participants support the goals and objectives of the UHC Law. Still, perceived barriers refer to the lack of and improper use of funds, the need to clarify the implementing guidelines, and the role of politics. The participants indicated that solidarity and social connectedness with health system adaptability and resilience are enablers for the success of UHC reforms.

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Conclusion. Proposals to mitigate the barriers include expanding the funding source, clarifying rules on the financial management system, and providing guidelines on health delivery integration to ensure access to patient care. Decentralization with autonomy will allow the stakeholders to align health programs with local needs. Proper representation in decision-making bodies is desirable to establish strong community involvement and solidarity. Resilience and adaptability based on a feedback loop are imperative.

Keywords: universal healthcare, health financing, integrated networks, health reforms, Philippines

INTRODUCTION

Universal healthcare (UHC), one of the United Nations' Sustainable Development Goals, aims to provide equitable access to quality care with protection from catastrophic financial risk.[1-3] In most low-income and low-middle-income countries (LICs and LMICs), strategies to achieve UHC include integrating the health delivery system across the care continuum, expanding the health fiscal space by increasing funding, improving benefit packages and population coverage, strengthening regulatory functions by leveraging the strategic purchasing power of the payer, and decentralizing administration with accountability and community involvement.[4-6] There is no standard roadmap, and each country needs to adapt to its existing system and available resources.[7]

Studies on UHC implementation in LICs and LMICs in Asia, Africa, and Latin America highlighted problems associated with the coverage of the informal sector, the design of benefit packages relevant to the health profile of the members, the readiness of the providers to render expanded services, and the need for continuous adjustments during program implementation.[4-6] The expansion of government subsidies to enroll and cover informal members, similar to those living in severe poverty, was proposed as a solution, as efforts to facilitate enrollment through education campaigns and facilitation programs have failed.[8] Additional subsidies may, however, pressure government budgets or induce informality, where members circumvent premium payment by misrepresenting employment status. A robust system to track ability to pay was recommended as a deterrent.[8,9]

The issue of benefits package coverage requires a regular review of emerging disease trends as most LICs and LMICs are developing and lifestyle-related noncommunicable diseases are increasing. Focus on primary care rather than hospital-based curative care is recommended.[10-12] A single risk pool is also desirable for cross-subsidization and simplification of benefit coverage.[6] Health technology assessment capabilities should be enhanced to evaluate evidence-based and cost-effective care. Differing benefit packages, copayment, and exclusions may need to be defined to ensure financial viability.[5]

The issue of health facilities' readiness to provide skilled personnel, equipment, and medicines is affected by wide variations brought about by geography and political decisions, especially in devolved settings.[13] In countries where health delivery was decentralized to local governments, enhanced monitoring and involvement of civil society to make the local government accountable for outcomes was a critical success factor.[4] However, decentralization created issues as local governments had varying resources and capabilities to administer the health system.[14] The rules of fund flow from the national government to the state and the state to the municipalities were defined, and quality outcomes were monitored with mixed success.[4] Assessment tools were used to objectively measure the capability to offer coverage of the expanded services brought by UHC reforms.[15,16]

In 1995, Republic Act (RA) 7875, or the National Health Insurance Act, established the Philippine Health Insurance Corporation (PhilHealth) as the Filipinos' unified national social health insurance corporation. Coverage had gradually increased through the years, especially in 2012 when RA 10351, or the sin tax on tobacco, alcohol, and eventually, sweetened beverages, enabled the national government to pay for premiums of indigent patients, disabled members, and senior citizens.[17-19] The benefit package has minimal variation across the different contributing groups, and favors the indigent and senior members under a no-balanced billing rule in public hospitals.[19] Nevertheless, PhilHealth's support value is insufficient, resulting in a higher incidence of catastrophic expenditures (measured if health spending exceeds 10% of household income). In 2015, catastrophic health spending added 1.4% to the poverty incidence (calculated at USD 3.10 per day poverty threshold), equivalent to 1.4 million people falling below the poverty line.[20] In the same year, 6.7% of the total population experienced total catastrophic spending in excess of the 10% household income threshold, while the catastrophic expenditure for surgical care was at 25% in 2020.[20,21] Although the contribution is mandatory, PhilHealth possesses no enforcement capabilities to ensure compliance with the premium payments.[17]

In 2019, the Philippine Congress passed the UHC Law or RA 11223 and its implementing rules, which mandate that Health Care Provider Networks (HCPNs) be established within geopolitical boundaries of a province or a highly urbanized city.[22] (Figure 1)

The organizational setup aligns with the 1995 Local Government Code that devolved health delivery to the local government, with subsequent fragmentation of health service delivery.[23,24] Most regional and public tertiary specialty hospitals, however, remained operationally under the national Department of Health (DOH) leading to difficulties in continuity of care protocols.[17]

PhilHealth and the DOH will leverage their strategic purchasing power to negotiate and affiliate HCPNs through service-level or Terms of Partnership agreements. The prospective payment will be through a special health fund

(SHF)—run by the City or Provincial Health Board (C/PHB)—that will determine the compensation of health services for HCPN member facilities and physicians.[19] (Figure 2)

Despite the implementing rules of the UHC Law, questions on how the reforms will be operationalized remain from stakeholders. Details of the guidelines are continuously being developed as implementation is staged depending on the local government units' (LGUs) maturity assessment. Most comments from stakeholders are anecdotal, and published reports more commonly cover assessing the readiness of the LGU to implement reforms. Despite numerous

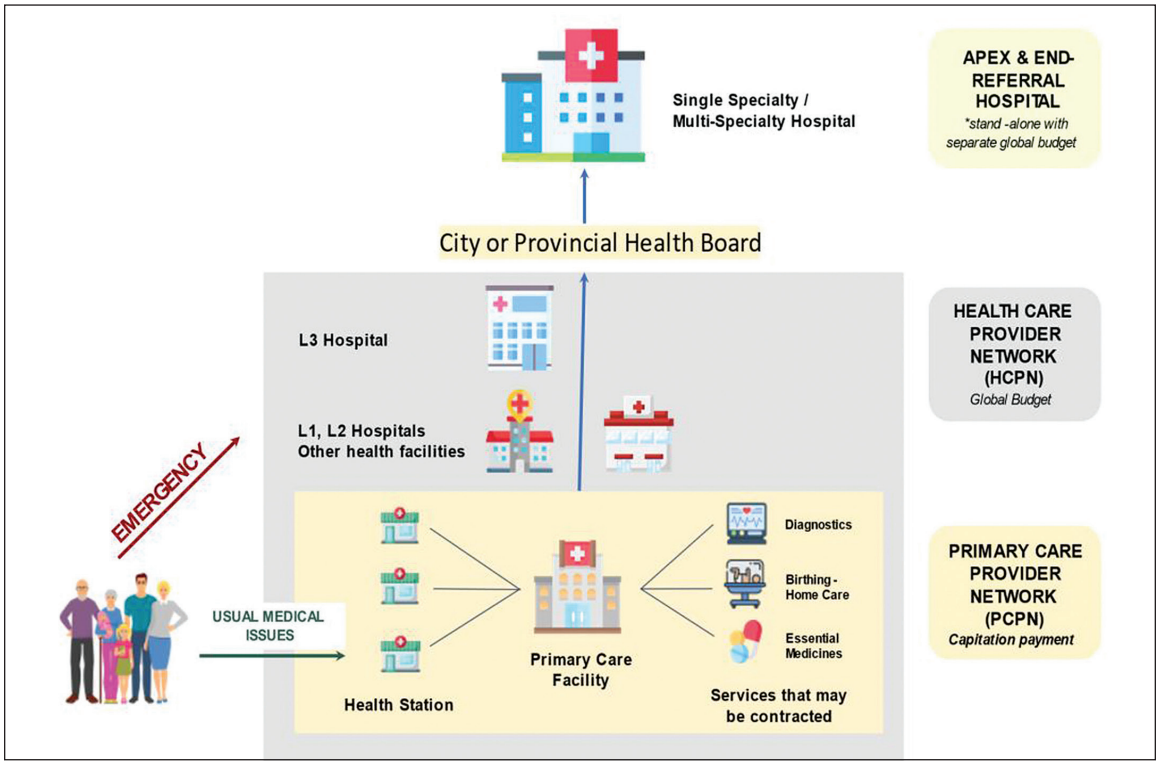

Figure 1. The components of the Health Care Provider Network (HCPN) with payment mechanism.[19]

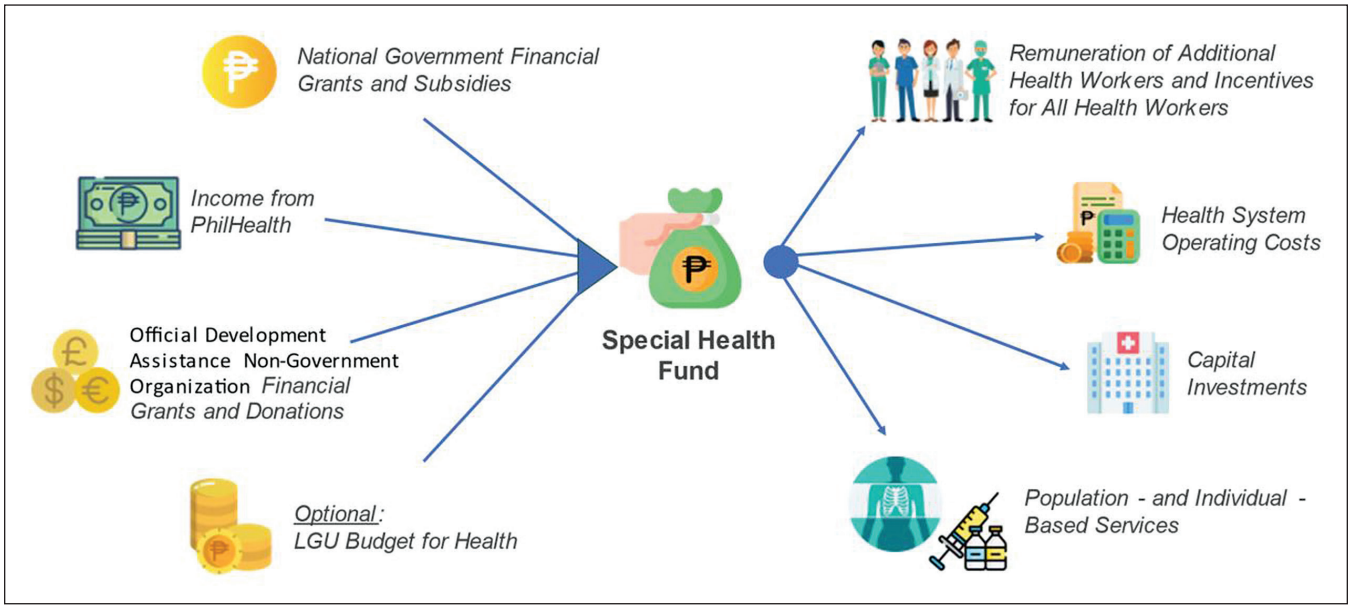

Figure 2. Organization of Health Care Provider Networks' (HCPN) Special Health Fund (SHF) with its sources and uses.[19]

memorandums, stakeholder meetings, and online tutorials, different LGU executives have various interpretations of the enabling rules, which adds to the complexity of the implementation of the reforms.[15,25] There should be in-depth documentation and an analysis of the bottlenecks experienced by stakeholders on the ground.

This qualitative study, using a highly inductive approach called conventional content analysis, and guided by the World Health Organization's (WHO) Building Blocks Framework, aimed to determine the understanding of the UHC Law's implementing rules from providers, payers, and regulators in three representative provinces in the Philippines. The study also aimed to detail what is expected by and from stakeholders to implement UHC successfully.

METHODS

Setting

Batangas, Bataan, and Catanduanes, which are three provinces in Luzon, were selected as project sites. The provinces selected provide a variety of economic, geographic, and political characteristics to enrich the data. They were already released from a quarantine status during the study and did not experience severe COVID-19 incidence during the height of the pandemic.

These provinces also represent, population-wise, a large, medium, and small province with different financial and health system maturities. They are included in the country's UHC advanced implementation sites. Batangas is among the top five wealthiest provinces, while Bataan and Catanduanes are in the middle and lowest quartile of Philippine provinces, respectively, regarding gross income.[26] The health facility (hospital beds and primary care clinics) and basic medical technology needs (x-rays, ultrasounds, dialysis, and electrocardiography) of the different provinces, based on an analysis of the prevalence rates of disease and population growth rates, are substantial to approximate middle-income status countries.[27]

Selection of Participants

Participants from the provider, payer, and regulator groups were selected based on their key roles as decision and policy makers. An inclusion criteria based on length of experiences, role in the UHC ecosystem, and private/public sector exposures were developed and used as a guide to recruit participants, ensuring diverse key perspectives.

The provider group comprised hospital chiefs, administrators, city or municipal health officers (C/MHOs), and practicing physicians. The hospital chiefs or administrators managed facility operations, and were divided into public and private facilities. C/MHOs oversaw the health programs of their respective cities or municipalities and were classified under two categories: cities, 1st and 2nd class municipalities, and 3rd, 4th, and 5th class municipalities. Physicians came from a combination of private and public practice settings. In each focus group discussion (FGD), there was at least one physician for each basic specialty: Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Surgery. All specialists are graduates of accredited residency programs of their respective specialty.

Up to 20 hospitals for each province were identified for the provider sample through purposive sampling, based on highest bed capacity. Half of the hospitals per province were privately-owned, and another half were publicly owned. Up to 20 C/MHOs in charge of their respective constituents' health programs, including primary care, were sampled per province based on the largest population size. For the physician sample, up to 20 physicians per province were identified with at least one from the fields mentioned previously. The participating hospitals were asked to provide the physicians with the most volume of patients in each of the specialties mentioned previously, and divided into the 20 slots allotted.

The payer group administers the relationship between the regional PhilHealth office and the PHB, and will define the service level agreements with providers. This group comprised the provincial governor, provincial health officer (PHO), and regional head of PhilHealth.

The regulator group oversees the policy and implementation process of UHC reforms. They comprised principal stakeholders for such efforts: PhilHealth's national vice president (VP) for UHC and the Commission of Audit's (COA) chief auditor-in-charge. The COA auditor, however, declined to participate, citing that audit rules are still being formulated and yet to be approved.

A purposive sampling technique was used to provide the best representation across different provinces. Variations in economic conditions, based on provincial income, physical geography, and location on a main island, Luzon, versus an island province, were considered. The purposeful sampling of participants in each province assumed their roles as payers and providers at different settings (private or public), levels (municipal, city, provincial, and regional), and length of practice or service.

All public hospital chiefs and C/MHOs of each province were invited. At least 50% of those invited agreed to participate. Private hospital administrators were selected based on the facilities' bed capacity, starting with the biggest, but there is variability in numbers and sizes across the different provinces. Up to seven private hospitals per province participated in Batangas and Bataan, but only one in Catanduanes, as the smallest province had fewer private hospital providers. Based on specialties and availability, there is a mix of junior and senior physicians with five or more years of practice, respectively, with up to 75% for the latter. The payer and regulator groups were elected or appointed government officials and were directly invited. Two PHOs invited provincial board members to the interviews, who were also accommodated.

Due to the devolved nature of health delivery at the identified sites and the DOH-retained hospitals are apex

hospitals outside an LGU-operated HCPN, the national and regional DOH officers were excluded as participants.

Data Collection

The Philippine-based researchers, with private and public practitioners represented in all FGDs and in-depth interviews (IDIs), conducted six FGDs each for two provinces and four FGDs for one province, with a total of 69 participants for the provider group. Providers were divided into MHOs for 3rd, 4th, and 5th class municipalities, C/MHOs for a city, 1st and 2nd class municipalities, chief of public hospitals, chief or administrators of private hospitals, physicians with more than five years of practice, and physicians with less than five years of practice. Only four FGDs were conducted in Catanduanes, with the MHOs and physicians combined into one group each due to the province's smaller number of provider subgroups. The FGDs were arranged in a function room of an accessible private hotel. There was a total of 16 focus groups for the three provinces. An understanding of the economic impact of a new capitated reimbursement was obtained.

For the payer group, IDIs in each province were done with the local chief executive (LCE), the PHO with other PHB members, and the regional PhilHealth VP. Eight IDIs were conducted across all three provinces, while a separate interview was held with the national regulator for a total of nine IDIs. All IDIs with payers and regulators were arranged in their respective offices. The corresponding author conducted all the interviews. He is a medical doctor and a public health researcher specializing in health economics and UHC public financial systems in the Philippines. The four FGDs involving C/MHOs were led by a research assistant, who possessed the technical training to facilitate interviews and was formerly an MHO. He is also a public health professional with expertise in health financing and local health systems.

Three sets of semi-structured interview guides were prepared to probe into the respective experiences of each participant group both for the FGDs and IDIs. The semi-structured interview guides are broad in nature covering the key areas mentioned. When needed, participants were asked follow-up questions to probe into their answers, but the interviewers ensured that these probing questions did not deviate from the stated topics. Questions for the providers revolved around perceived impacts on how their care delivery will be affected by the HCPN integration, as well as the effects of governance on their medical practice and how medical operations are impacted.

Those for the payer group elicited participants' understanding of governance and operating structures needed to run a provincial HCPN effectively, while also covering topics such as provider contracting models, resource allocation, and the impact of UHC on a province's public health objectives. Questions drafted for the regulator focused on their understanding of the strategic purchasing power of PhilHealth and DOH.

All discussions and interviews were completed between August 3 to November 15 2022, lasting one to two hours for the provider group and an hour and a half to two hours for the payer and regulator groups. Everything was audio recorded after each participant read, signed, and obtained a copy of their Informed Consent Form (ICF). The names of the participants were recorded, and a subject number was assigned before the interview. The subject name attached to the given code remained strictly confidential and was only known to the researchers. Throughout data analysis and in the discussion of findings, only the participants' assigned code numbers were used to abide by RA 10173 or the Data Privacy Act of 2012, as well as other confidentiality agreements.

All FGDs and IDIs were done in English or a combination of English and Tagalog. The recordings were transcribed from the native language to English to produce transcripts. After the transcripts of the audio recordings were completed by one of the researchers, the other researcher examined the transcription and the audio files to ensure adequacy. Another researcher, a medical doctor fluent in Tagalog and with expertise on health systems administration, reviewed the transcripts, re-transcribed the English translation of the Tagalog portions, and verified these with the original recordings. The files were electronically saved in separate, limited-access folders on the personal computers of the researchers. The master document containing the patients' names, assigned code number, contact information, and basic demographic information was stored in a separate folder in a password-protected computer, secure from unauthorized access. Data collected will be stored for a period of five years for the purposes of data verification. Following this period, all information collected, including any copies, will be permanently erased from computer drives.

Researcher reflexivity was also observed throughout the study process. There was an awareness of the Philippine-based researchers' experiences in UHC implementation unique to the local contexts, and the potential of this background in shaping the appreciation of the participants' insights. This was mitigated by engaging with all authors from diverse backgrounds in validating the interpretation of responses, ensuring that the analysis accurately aligned with the perspectives of the participants.

Data Analysis

Analysis followed a conventional content analysis approach, which sought to identify perceived barriers and enablers to the acceptance of the implementing rules of the UHC Law. Conventional content analysis is an inductive approach to analysis that allows concepts to flow directly from the data and does not rely on preconceived theoretical frameworks.[28] Following a complete review of the dataset, a subset of interviews was open-coded for the purpose of identifying key concepts related to the understanding of UHC objectives and requirements for proper implementation. The initial codes were reviewed by the researcher together with a medical anthropologist and a qualitative researcher, and

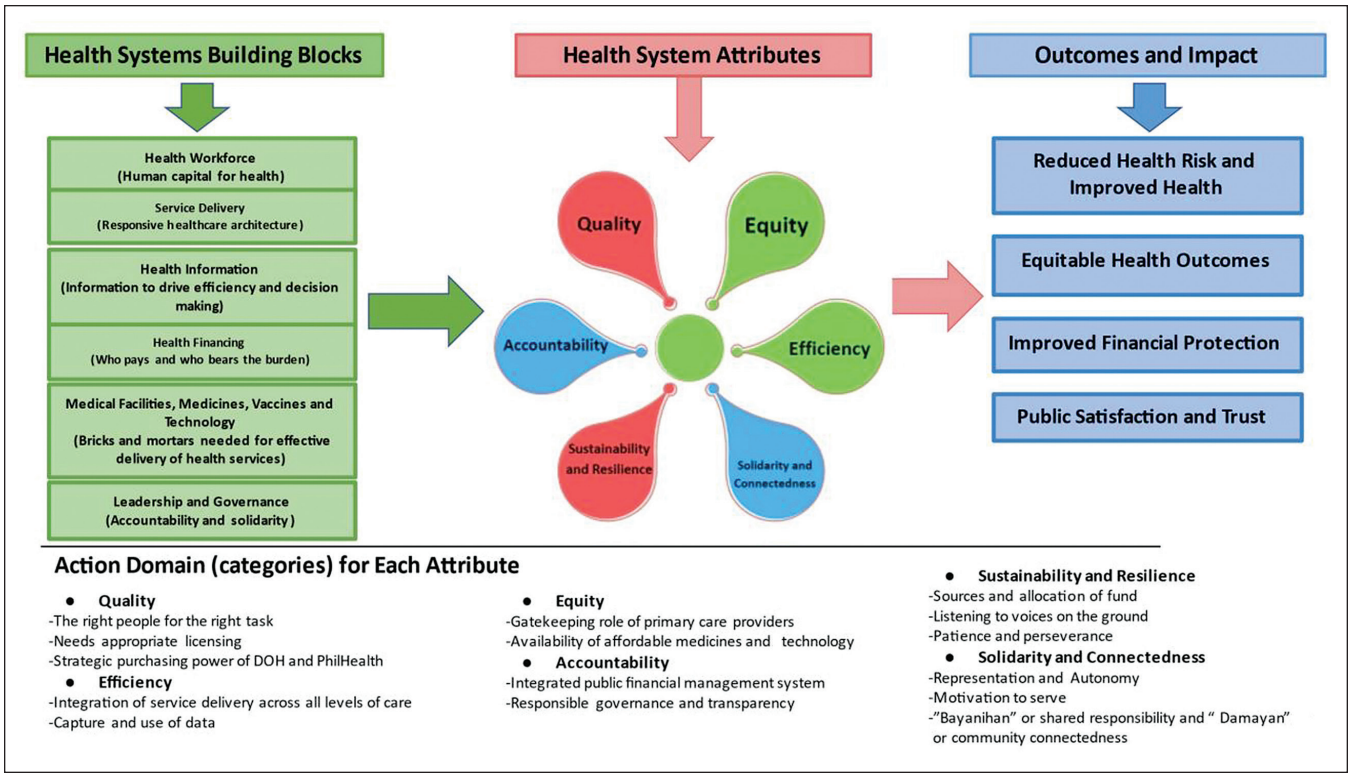

Figure 3. TImpact of Action Domains (Categories) on health system attributes resulting in desired outcomes of UHC.[29]

piloted to finalize a codebook. Using the finalized codebook, the researchers coded all transcripts using Dedoose, a qualitative data management software. Initial themes were developed and subsequently reviewed and revised through an inductive iterative process. These were then further revised with inputs from a health economist and implementation science professor, until a final set of 15 themes and five sub-themes emerged.

These inductively-derived themes and sub-themes were then mapped deductively onto the WHO building block framework,[3] which is illustrated in Table 2 of the results. Overall findings based on data and literature reviews were also inductively matched with the WHO Western Pacific's framework on "Impact of Action Domains (Categories) to Health System Attributes" that positively influenced the desired outcomes of UHC. This matching enabled the content-specific, inductively derived themes to be more legible across contexts and enhanced the relevance of the findings. After matching the themes to the categories, the five themes for enablers and barriers were determined.[29] (Figure 3)

Ethical Considerations

The exemption of this research from additional Institutional Review Board (IRB) reviews was approved by the Harvard Faculty of Medicine - Office of Regulatory Affairs and Research Compliance last March 2, 2022. The study also obtained a "Certification of Exemption from Ethical Review" from the University of the Philippines Manila - Research Ethics Board last April 11, 2022.

RESULTS

A total of 84 stakeholders participated in the study, 69 of which were providers, 14 payers, and one national regulator. The participants' average length of service is 19.9 years with a range of 2 to 49 years.

All 17 public hospital chiefs and six of the 14 private hospital chiefs are physicians. The MHOs of 3rd to 5th class municipalities have the shortest average years of service, at nine years, as these are usually entry-level positions. There is a substantial length of service among the other groups of payers, providers, and regulators, with an average of 14.6 years for private physicians (range of 2 to 38 years) and 28.5 years for public hospital chiefs (range of 2 to 39 years). (Table 1)

The resulting categories under each WHO building block were matched with sub-themes showing the barriers and enablers. The sub-themes illustrate that the participants support the goals and objectives of the UHC Law, while the lack of and improper use of funds, the need to clarify implementing guidelines, and the role of politics were cited as perceived barriers. Nonetheless, solidarity and social connectedness, along with health system adaptability and resilience, were shared by the participants as enablers for the success of UHC reforms. (Figure 4 and Table 2)

Table 1. Participants by Stakeholder Group

Stakeholder Group	Number	Average years in service	Years in service (range)
Provider			
MHOs of 3rd to 5th class towns	5	9.0	2 - 18
MHOs of City to 2nd class towns	8	20.8	2 - 35
Public Hospital Chiefs	17 (17 are Public Doctors)	28.5	2 - 39
Public Physicians	4	22.0	4 - 33
Private Hospital Chiefs	14 (6 are Private Doctors)	28.1	15 - 49
Private Physicians	21	14.6	2 - 38
Total	69	20.7	2 - 49
Payer			
PHO/PHB member	8	15.1	
PhilHealth Regional Head	3	20.7	
LCE	3	15.3	
Total	14	16.6	
Regulator			
National PhilHealth Executive	1	25.0	
Grand Total	84	19.9	

MHO – municipal health officer, PHO – provincial health officer, PHB – Provincial Health Board, LCE – local chief executive

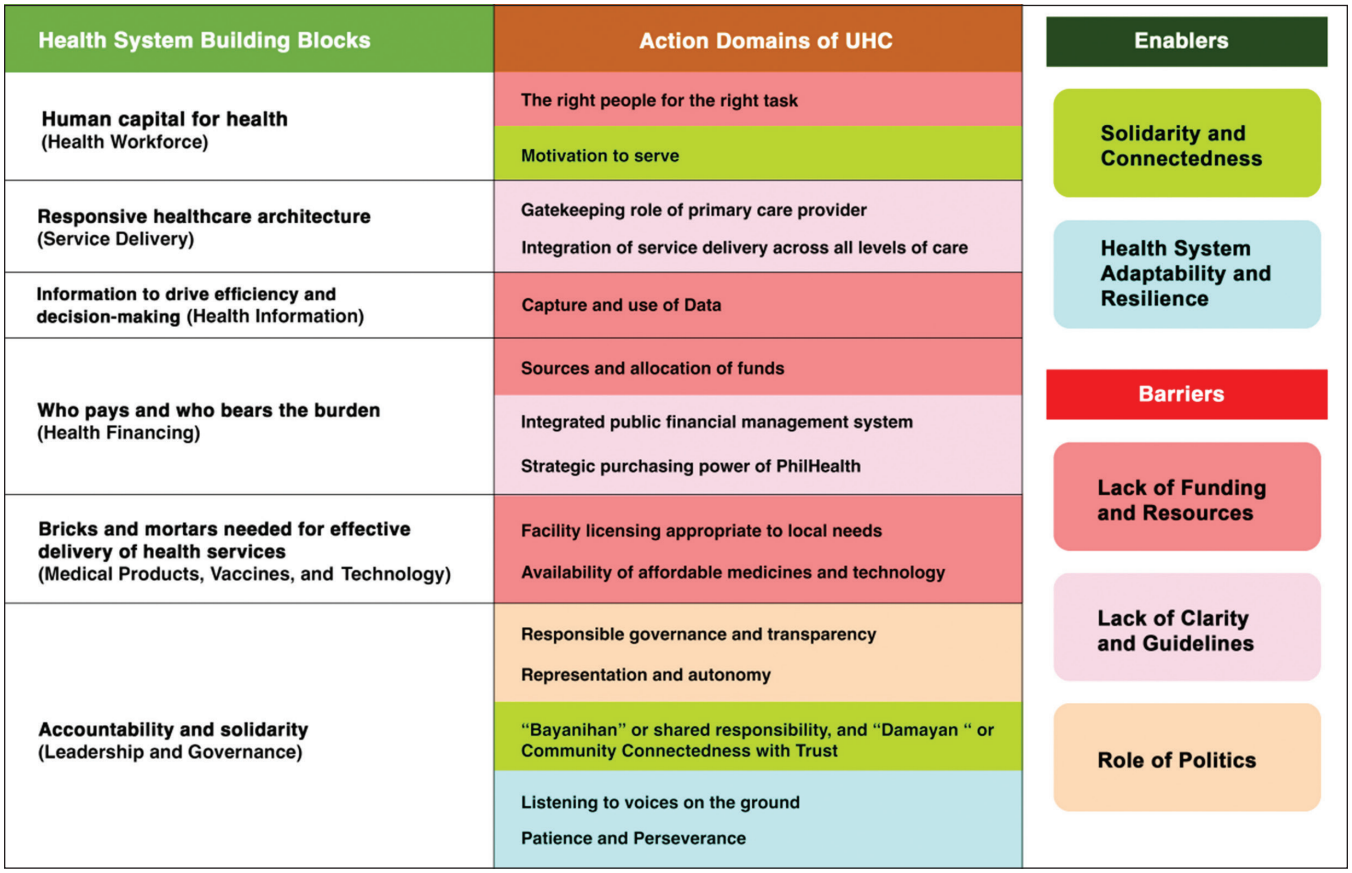

Figure 4. The WHO Building Blocks matched with Categories as action domains and identified as barriers or enablers subcategories.

Table 2. Explanation of Relationships of WHO Building Blocks with Categories Identified under Enabler or Barrier Subcategories[3]

WHO Building Blocks with Categories	Enabler or Barrier Subcategories	Explanation of Relationship
1. Human capital for health (Health Workforce)		
A. The right person for the right task	Lack of Funding and Resources	Limited budget, caps on human resources cost allocation, and shortage of candidates limit the hiring and retention of permanent health workers.
B. Motivation to serve	Solidarity and Connectedness	Health workers developed strong ties with the community due to the presence of relatives, as well as the opportunity given by the government—through public health programs—that created a significant difference in health delivery.
2. Responsive healthcare architecture (Service Delivery)		
A. Gatekeeping role of primary care provider	Lack of Clarity and Guidelines	There are fears that the primary care physicians are not adequately trained, and there may be a dilution of focus on population health and possible delayed or missed diagnosis. Clear clinical practice guidelines and training are proposed to mitigate these fears.
B. Integration of service delivery across all levels of care	Lack of Clarity and Guidelines	Optional integration of local health units and the absence of a model for private health facilities are perceived barriers to a functioning HCPN. Guidelines on inter-referrals shared services efficiencies and providers' desired payment.
3. Information to drive efficiency and decision-making (Health Information)		
A. Capture and use of data	Lack of Funding and Resources	Physician providers raised the need for an internet connection and a unified health information exchange. The standard for health Information Technology (IT) interoperability should be imposed, and telecommunication companies should be compelled to provide internet services and patient education on the use of health technologies.
4. Who pays and who bears the burden (Health Financing)		
A. Sources and allocation of funds	Lack of Funding and Resources	The substantial out-of-pocket expense of patients due to low government health expenditures, inadequate support value of PhilHealth, and unavailability of medicines/services in public facilities are indications that the public health expenditure is insufficient or inefficient.
B. Integrated public financial management system	Lack of Clarity and Guidelines	Needs-based budget is not followed, and the allocation of funds from the SHF to provide equitable access is dependent on the political decisions of the PHB. Providers and payers desire an end-to-end process map and rules.
C. Strategic purchasing power of PhilHealth	Lack of Clarity and Guidelines	The shift to a prospective payment system is envisioned to push for efficiency and quality of care. Budgeting is projected to be more proactive and efficient.
5. Bricks and mortars needed for effective delivery of health services (Medical Products, Vaccines, and Technology)		
A. Facility licensing appropriate to local needs	Lack of Funding and Resources	The licensing standard set by DOH does not consider local site conditions, and LGU facilities need resources to upgrade and be at par with private facilities.
B. Availability of affordable medicines and technology	Lack of Funding and Resources	The medicines and technology that will be reimbursed by PhilHealth and acquired by the HCPN are substantial and should be reviewed regularly. The procurement process has perceived benefits of economies of scale and transparency.
6. Accountability and solidarity (Leadership and Governance)		
A. Responsible governance and transparency	Role of Politics	Regulators and payers perceive the SHF to streamline and simplify fund flow. To circumvent changes in LCEs, a binding contract is proposed with the oversight of COA.
B. Representation and autonomy	Role of Politics	To mitigate the discretionary powers of LCEs, proper representation of local stakeholders is proposed by providers and regulators. Civil society and patient advocacy involvement are also critical.
C. "Bayanihan" (shared responsibility) and "Damayan" (community connectedness with trust)	Solidarity and Connectedness	Participants expect community ownership and involvement once trust is developed and if there is transparency and representation. A sense of social contact and communal responsibilities are developed with improvements in access and quality of care.
D. Listening to voices on the ground	Health System Adaptability and Resilience	Regular consultation enhances community ownership and involvement.
E. Patience and perseverance	Health System Adaptability and Resilience	The participants know the reforms will take time but are committed to continuing forward.

Barriers

1. *Participants are concerned about the lack of funding for the resources and building blocks required for successful UHC implementation.*

1a. The right person for the right task. All the participants agreed that the availability of well-trained physicians, nurses, and paramedical professionals is crucial to providing quality care, and that having the correct number of capable personnel based on local needs and conditions is affected by inadequate budget and restrictions. Providers consequently proposed that proper compensation, training, and resources to make appropriate diagnoses and treatment be implemented to promote the retention of competent staff and a responsive health workforce.

> *There are different salaries and incentives among rural health physicians (RHPs), nurses, and midwives in various municipalities. We all know the compensation is low, especially for job orders… And if it's a job order, there is no security of tenure. That's why many are leaving, and then they will just be replaced with a new one. Hopefully, they will be able to make the healthcare workers permanent. – MHO, 5 years (years in service)*

> *There must be a complete set of specialists, and the subspecialist and the medications [should] also be available, as well as diagnostics and therapeutic modalities so that there will not be any delay in diagnosis or treatment. – Private physician, 2 years*

1b. Capture and use of data. Providers were aware that using technology to lessen workload, through integration of data processes, is imperative to give more focus to providing care. These, however, require substantial capital investment and a robust data repository system. LCEs understood that data analytics can objectively guide resource allocation and forecasting of budgets, and suggested integrating health data with community-based monitoring systems to drive health programs. Providers recommended patient IT education to navigate the health system effectively.

> *There might be areas here in Bataan with a more significant sick population that need more interventions, or places where people are healthier for whatever reason. This is the data. These are the situations in the different municipalities… So, when we have provided the resource needs, we can have an explicit formula for the preventive side. – LCE, 15 years*

> *Education and training are needed. A lot of our subset of indigent patients are usually not that familiar with these systems. Particularly the elderly, the middle-aged, or the boomers, so they're not well-versed in these matters… So that can be a hassle because when we do Zoom consultation during eKonsulta, you have to register and get a ticket. – Public Hospital Chief, 18 years*

1c. Needs-appropriate licensing. Providers shared the same sentiments that licensing is essential for safe health facilities. The current process is perceived as unrealistic or inappropriate, demoralizing public providers who fear that losing their operation permits will affect the access of poorer patients. The required investments to comply are substantial, especially for old facilities that have grown organically. Public providers urged that licensing be locally needs-appropriate after proper consultation, and not based on a one-size-fits-all standard. Public hospital operators hoped for service capabilities to be the same as the private sector; thus, there is a need for HCPNs to invest in equipment.

> *We are asking DOH to review them because we were not consulted when they were created. We're a government facility, and it's hard for them not to involve us. We serve the community, and they will give us a hard time with all the requirements. Because if we are not accredited, we will not be given the license to operate, and with no accreditation of e-Konsulta, everything stops. – MHO, 22 years*

1d. Availability of affordable medicines and technology. The physicians expressed that reimbursable treatment and services should be assessed frequently. Public physicians proposed that the drug formulary, compensable diagnostic, and therapeutic modalities be updated to maintain evidence-based treatment standards up to par. The regulators and payers expected economies of scale, brought about by consolidating purchases, will decrease the cost of medicines and equipment.

> *I always attend conventions. The problem I have right now is that even if you want to give these patients new medicines, our medicines are based on the national formulary, which is five years late. So even if we want to treat these patients, just like in the private setup, we cannot do it because we cannot buy the newer medicines and must defend why we want them. – MHO, 33 years*

1e. Sources and allocation of funds. The participants were hopeful that the HCPN's SHF will consolidate all the fund sources and simplify fund flow with guidelines that will not allow its use for other purposes. LCEs were concerned that additional revenues brought about by further devolution will be less than the cost of services transferred to the local government. The regulator explained that members need to pay their premiums while the national government must continuously provide subsidies for the disadvantaged. Furthermore, additional funds should be provided for the coverage of the informal sector. LCEs wanted the national government's safety nets, like the Malasakit and the Medical Aid for Indigent Patients (MAIP), to be sustained. Participants also envisioned the UHC program being

sustainable using a whole-of-government approach, with proper governance and transparency.

> *The sin tax laws and all other national government tax or non-tax revenues fund the General Appropriations Act. Now, the money from agencies providing funds for health services, like the PAGCOR and the PCSO funds, is incorporated through the UHC. They previously had mandates to provide for their health and medical health services. Now, their money is also integrated into the UHC fund for sustainability and the expansion of benefits. At the national level, the money will be consolidated to avoid duplication in the use of this money. At the local level, financial integration into one fund, the Special Health Fund, will make sure that the money for health will not be co-mingled – Regulator, 25 years*

2. Providers, payers, and regulators agree that there is still a need to clarify and provide details on guidelines and implementing rules to avoid confusion and uncertainties.

2a. The gatekeeping role of primary care providers. Although the participants acknowledged primary care gatekeeping as the right step to provide equitable access, there were concerns that prioritizing primary care providers as the initial touchpoint would focus on curative medicine and possible treatment delays caused by misdiagnosis. Physicians were concerned that there is a lack of guidelines, while providers recommended proper physician training and patient education to enhance trust in the health delivery system.

> *Basic care should be with the primary care provider, like simple asthma or allergy, that should not be sent to a district hospital. Those needing operations, admissions, and things they could not do should be with a district hospital. So, gatekeeping is vital to the success of the healthcare provider network. – Public Hospital Chief, 31 years*

> *Primary care physicians should have at least the essential core competencies to diagnose basic diseases. Now, there comes the problem, for example, if the physicians are not competent enough. Well, you know, it would be catastrophic. The patient would be referred to the proper doctors later when the disease had progressed. – Private physician, 8 years*

2b. Integration of service delivery across all levels of care. The participants believed that there are benefits to integrating service delivery, resulting in the pooling of resources, economies of scale, and complementation. The desired result is a comprehensive service delivery system covering the whole continuity of care. However, payers feel that challenges to this collaboration appear to be related to fears of losing control and share of the fund. To circumvent these issues, participants advised that regulators provide clear operating and financial guidelines to assure participants, and consequently, earn their commitments. In the interim, public providers recognized the need to integrate private facilities into their health delivery through a negotiated outsourcing contract. They hoped that this would result in guarded optimism and critical collaboration.

> *Integrating is more advantageous because if you are a network provider and cannot provide the needed care, you are given an option. I said, why isn't the approach inclusive? Because the system that will happen is exclusive, they will not include you if you do not sign an affiliation in a network. So, I said: "What will happen there? I'm not an island." So anytime I cannot provide services, I refer to or access what they call a network, and it looks like that will happen. – MHO, 8 years*

> *How can integration be under Provincial Health Office to form the health delivery ecosystem? It cannot be; they are DOH. The province cannot dictate the MHO because its boss is the mayor. Yes, we can agree with the municipal mayor or local government. But that's just an agreement. – Public Hospital Chief, 26 years*

2c. An integrated public financial management system. Payers and providers acknowledged a need for transparent end-to-end financial processes. The desired outcome is a more responsive bottom-to-top budgeting process with accountability and equitable fund allocation. There are mixed views on how the SHF should be distributed, with some agreeing that it should be based on needs, while others believing it should be based on productivity. However, the consensus is that good outcomes and compliance with metrics should be incentivized and rewarded appropriately. The participants concurred that involving the different agencies in drafting the guidelines on SHF use, in consultation with stakeholders, was necessary. Subsequent training and communication down to the level of the patient members were proposed. Such guidelines should be defined in a standardized public financial management system supported by a capable financial IT backbone.

> *For example, the province's budgeting process is not straightforward if a municipality is not on time to pass its plans. We also have favoritism that will come into the picture, like which municipality will get their fund first... Then, how will they distribute? For example, how much will they give from that if we can contribute 50% of the revenue? Will they provide all that reimbursement from PhilHealth or according to needs? Is that equitable? – MHO, 32 years*

> *They should make good all their plans because, again, that will be the input for the funding for the whole system in the province. So, several tools will hopefully be used to ensure that the information from the operations is taken in. A lot of, one—training, and two—capability*

building, is needed, and a lot of rethinking should be done. But one of the principles of UHC is the whole [of] government approach, especially in policy development. Hopefully, with the whole-of-government approach, it's no longer going to be top-down decision-making but rather bottoms-up decision-making. – Regulator, 25 years

2d. Strategic purchasing power of PhilHealth and DOH. The participants were wary of the lack of clarity on the prospective payment mechanisms. Regulators foresee that the shift in global payment methods will push physicians to be more efficient and evidence-based. They hoped that standardizing professional fee payment will encourage physicians to serve underserved areas. The LCEs hoped to use the prospective payment to make the HCPN more proactive and informed in budgeting.

I think it would push us to develop the standards of care… And I think we would also make for uniformity across all the players. And I would also see coming up with the standardization, those that are non-essential to care, taken off already. So that compensation should be according to patient outcomes and level the playing field among all providers. – Private Hospital Chief, 18 years

I think we can try this prospective payment scheme in advance. One is to teach us how to manage the funds better and be precise in using such funds... Hopefully, we can learn how to utilize it, and if indeed that is what we need, we can manage better. And if not, we can identify why it was insufficient, and hopefully, PhilHealth will make the adjustments. – LCE, 15 years

3. *All the stakeholders have concerns regarding the role of politics or how to mitigate them. The need for autonomy, clear reporting lines, and accountability, is necessary.*

3a. Responsible governance and transparency. The providers and payers were concerned about the fragmentation caused by the devolution of healthcare delivery, which provided LCEs substantial discretionary powers to decide on programs and the utilization of different health funds. One regulator hoped that streamlining the various fund sources into a single SHF will provide more governance and transparency. The providers felt anxious that a change in LCEs, who are up for elections every three years, may affect the continuity of the local health plans and the sanctity of agreements. The payors preferred a legally binding contract to deter revisions or reversal of commitments.

Of course, checks and balances are still applicable in all government institutions. For example, we have the Commission of Audit, which checks everything that goes in and out of the pocket of the local government and national department as mandated by the universal health care law. In cooperation with all the agencies, including the COA, PhilHealth, and the DOH, they will implement guidelines to manage the special health fund. – LCE, 27 years

3b. Representation and autonomy. The participants agreed that there should be a competent representation of all stakeholders in the C/PHB that will govern the HCPN. The PHOs want the disciplinary powers of the HCPN and reporting lines to be defined, as there are perceived overlaps between the PHB and mayors. There was a clamor among the LCEs and public providers to renationalize the health system, but that would entail a long process of amending the law. Instead, once rules are defined, autonomy can be given to chiefs of hospitals and clinics, and there will be more accountability and responsiveness to the community's needs.

The board will be responsible for the operations of the whole provider care network. Of course, we can provide monitoring, utilization, and tracking so that we would know where the money is being used….. That's why those involved in governance must have financial management and procurement training. Making sure that there is representation from the lower levels to ensure that the concerns of those at the operational level are taken up at the board discussion so they should be well represented. – Regulator, 25 years

Right now, we are starting in some hospitals to have the autonomy to work around the economic enterprise, but no one has total freedom… it means they can now request the higher-ups for what they need. We would evaluate these, allowing us to gauge how well they work as managers… We would see how good they are in terms of forecasting and in identifying their needs. The money that used to be centralized with us had been given to them already so they could try managing it independently. – PHO, 31 years

Enablers

1. *Solidarity and Connectedness*

1a. Motivation to serve. The connectedness of health workers to the community where they have family, or the opportunities provided by public health programs for a starting professional, were reasons mentioned by participants when asked why they continue to serve in a community.

I immediately joined the Doctors to the Barrio program of the Department of Health. Then after one month, I transferred here to Catanduanes. For the first time, they had a doctor …. So, when I imposed systems and programs, it was hard, but later on, they were supportive, so I stayed there for ten years. My objective was when I left, the community would be self-reliant. – PHO, 31 years

1b. "Bayanihan" and "Damayan". The stakeholders agreed that once the roles and responsibilities of the provider, payer, regulator, and patients are defined, a more robust social contract and sense of solidarity will emerge in the same spirit of "Bayanihan" (shared responsibility) and "Damayan" (community connectedness and trust).

> *The shift in the Bayanihan principle under social health insurance will erode because if the government is paying for the premiums of the indigents, those who can pay are not paying their premium contribution. Now those who can't afford it are subsidizing those who can. Everyone should know their responsibilities. – Regulator, 25 years*

> *If the special health fund is fair, then equity will follow. It would follow a "Damayan system" for the wealthy, middle class, and poor. We must pool our resources; the fund can augment what a patient can't pay. That is what we think is ideal and what we want. – PHO, 12 years*

2. *Health system adaptability and resilience*

2a. Listening to voices on the ground. Stakeholders agreed that the people's voice on the ground should be heard. The providers constantly raised consultation with proper training and dissemination to facilitate UHC implementation. There are perceptions that they are not being listened to, and decisions are often made at the top. This involvement of stakeholders, patient advocates, and civil society in the reform process will strengthen their ownership and involvement.

> *Ownership is important. Because once you present something, it becomes something you own. It shows people it was worked on by many so that everyone is incentivized to be involved. It produces a feeling of ownership. – MHO, 5 years*

2b. Patience and perseverance. Respondents concurred that reforming a health system takes time and needs constant revisions. They cited the need for continuous communication, use of data, process evaluations, and reviews of policies with reinforcement of commitments and successes. The use of technology to educate, provide informed choices, and enhance connectedness is proposed to be harnessed.

> *As they said, this Universal Health Care is one step forward for public health, one step to make it better, but as they said, we still want to implement this in terms of leadership, synchronization, and navigation. There are still many things to refine; that's why we said it's a step forward; we need to persevere and refine the process we are going through because, as they say, we cannot conquer one thing by merely thinking about it. – PhilHealth Regional Head, 21 years*

DISCUSSION

The researchers found that the participants support the goals and objectives of the UHC Law as it leads to equitable access and financial risk protection. There are, however, several perceived barriers, the first being the lack of and proper use of funds. Funding sources must be enhanced through additional national and local budget allocation and efficient premium collection. Fund utilization based on local needs should be well defined through a bottom-up budgeting process with transparency and accountability mechanisms.

Second, there is a need for clarity in the implementing guidelines of the HCPN referral system, as well as a definition of the continuity of patient care and the public financial management system rules on providers' payment through the SHF.

Third, the role of politics can either contribute if there is visionary leadership, or be a barrier if health is not a priority agenda of the LCEs. Autonomy with checks and balances and an objective dashboard will help incentivize LCEs to perform appropriately.

As enablers, the participants indicated that solidarity and social connectedness through advocacy and community participation are essential. Coupled with health system resilience and adaptiveness, these are critical requisites for successfully implementing the reforms.

The study findings illustrated concerns about the financial sustainability of the reforms. There is a need to increase the government health expenditure as a percentage of the total budget, which in 2020 was at 8.7 %—below the average of 10.32% compared to ASEAN peers (Indonesia, Malaysia, Thailand, and Vietnam) (Table 3)—and 12% with high middle-income countries.[30,31] Efficient sin tax and PhilHealth premium collection should provide for the

Table 3. Comparative Health Spending Metrics of the Philippines versus ASEAN Peers in 2020[30]

Metrics	Philippines	Indonesia	Malaysia	Thailand	Vietnam
Healthcare spending as % of GDP	5.11%	3.41%	4.12%	4.36%	4.68%
Healthcare spending per capita (USD)	165	133	419	305	166
Government health spending as % of health spending	44.6%	55.0%	52.8%	70.4%	45.1%
Government health spending as % of the total government budget	8.7%	10.1%	8.6%	13.2%	9.4%
Out-of-Pocket Spending	45.0%	31.8%	35.9%	10.5%	39.6%
GDP per Capita (USD)	3,222	3,894	10,151	6,999	3,551

middle gap or the portion of the informal sector not covered by the national government's premium subsidy.[17,18,20]

Increased budget allocation, whether earmarked for health or from the general revenue, will contribute to the health facility enhancement fund that will be used to provide the facilities and equipment upgrades based on the gap analysis of the Philippine Health Facility Development Plan 2020-2040. The recruitment and retention of competent human resources necessary to operate the facility should be enhanced by upgrading the salary rates, educational and training curriculum, and licensing standards.[32,33]

The cost is projected at PhP 56 Billion or USD 1 Billion annually to achieve the bed-to-population ratio and primary care facility access to HMIC status by 2040, apart from the equivalent share of the private sector.[27] The amount excludes the cost of scholarships with return service agreements for graduates of public universities and colleges.[32]

The mandated increase in a premium collection of up to 5% of base pay and efficient premium collection will provide increased benefit coverage as PhilHealth shifts to a prospective payment system to push for outcome-based care and mitigate supply-side moral hazards.[17,34]

Consolidation of all the fund sources into an SHF simplifies fund management and disbursements. A clear financial information and management system to track the end-to-end flow of funds is necessary to provide payers the accurate billing and assure providers of reliable and timely payments.

The premium and tax collection will need a whole-of-government approach and strengthening of the social contract between citizens. At the same time, implementation capacities of the collecting agencies are enhanced through data analysis of interconnected databases. Incentives for good performance and outcomes should be in place.

Another critical success factor in the findings is the effective integration of different providers into the HCPN. This will provide allocative efficiencies by avoiding redundancies of services, economies of scale bringing procurement costs down, and human resource sharing, most notably for specialty care.[4,14] The strengthening of primary care gatekeeping, as seen in LIC and LMIC settings, with the appropriate training and referral guidelines to prevent the progression of diseases, should be prioritized.[11,12,35] A prerequisite to an effective inter-referral network is a robust Electronic Medical Record/Telemedicine system to lessen workloads, prevent frequent testing, and expand access.[17,19] To allay concerns about fund allocation, objective guidelines based on needs and performance should be instituted and enabled by an electronic financial information system.

The HCPN should use its strategic purchasing power to influence the providers to follow judicious evidence-based treatment guidelines.[34,36] The role of the private sector should be defined as their integration may be peripheral to the public HCPN on a temporary send-out basis. Once guidelines are clear, a shared management setup or a free-standing private HCPN can be done to provide market dynamics and sharing of best practices.[34,36,37]

The decentralization and autonomy of public service entities have been highlighted as the New Public Management System, which hopes to make decisions closer to situations on the ground, isolate the entities from the bureaucracy, and make administrators more accountable.[38,39] Decentralization takes the form of devolution with corporatization, where the entity's public nature is retained. On the other extreme, privatization with regulations to maintain the public good intent of the entity was also an option.[40,41]

An extensive literature review showed mixed results with outcomes dependent on size, political independence, models (private-public mix, non-profit, or purely public), ability to collect fees, and focus on the provision of the public good.[38,40] There is, however, a commonality in the factors affecting effective governance, accountability, and transparency. The only difference is the involvement of the local stakeholders or constituents, making LCEs and administrators more accountable to the recipients of the services.[40] The C/PHB can decide on the HCPN budgets, payment mechanisms, and human resource allocation, and has the onus of satisfying the community's needs. The board members should meet credibility criteria with the representation of providers on the ground. An objective dashboard to monitor the outcome of care, health promotion activities, and patient satisfaction is a way to make the board accountable.[29] The involvement of patient advocacy groups and civil society is essential to reinforce communal ownership leading to "Damayan" and "Bayanihan".

This qualitative study is not generalizable for the whole country. However, the study sites' different socio-economic and geographic characteristics considered variations in size, economic status, and physical accessibility. Representation from various stakeholders on the ground captured a wide range of experience. No particular population health program or health policies were discussed as the focus is on the UHC implementation process. There were issues related to discretionary political decisions that may violate some procurement and local government laws that were not directly asked during the FGDs and IDIs, which the participants implied or had some reservations about revealing.

No researcher is involved either as a consultant or an employee of the local or national government unit and the hospital facilities that participated in this study.

CONCLUSION

In conclusion, there is support for the goals and objectives of the UHC Law among the providers, payers, and regulators in the three study sites in the Philippines. There are perceived barriers and enablers based on the WHO building blocks. To mitigate the barriers, there is a need to expand the funding source, clarify rules on the public financial management system, and provide guidelines on the health delivery integration to ensure quality and patient care access.

A standard manual of financial operations, detailing how the utilization and sources of funds flowing in and out of the SHF, can be drafted with guidance from COA, rather than allowing the LGUs to develop different financial processes. Guidance on how to properly forecast and do capital budgeting should be included in the financial manual. Likewise, a standard continuity of care protocol based on evidence-based guidelines can support patient navigators and define service level standards across the continuity of care spectrum. Resource distribution and allocation of equipment will be more efficient as the spokes and hub set-up will decrease redundancies and lead to economies of scale.[42]

Decentralization with autonomy will allow local administrators and providers to align health programs with local needs. Proper representation of the stakeholders in decision-making bodies is desirable to establish strong community involvement and solidarity. The different plantilla positions in the support and shared services of the HCPN should be defined with their corresponding task descriptions, salary grade levels, and key performance indicators. The levels of authority on financial and operational decision-making should be clarified to hold people accountable and mitigate overlaps and confusions.

Resilience and adaptability based on a feedback loop are imperative. These measures will improve efficiency, quality, equity, accountability, resilience, and solidarity as health systems attribute to achieving UHC's goals and desired outcomes, as illustrated by Figure 4.[29] The role of civil society organizations as key stakeholders is also critical to amplify the voice of recipients of the care process. The road to attaining UHC is long and arduous, but there is a strong commitment from the providers, payers, and regulators to forge forward as long as processes are defined, administrators are accountable, and outcomes are objectively measured.

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Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

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