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Contracting for Health Care under the New Philippine UHC Act

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Abstract: The 2019 Philippine UHC Act provides one of the most recent examples of contractualization of health care. Despite the significant change it brings, it regulates contracting only marginally, so that the purpose and deployment of this mechanism remain largely unclear. This study examines how contracting under the new law can contribute to achieving the reform goals and, to this end, subjects the UHC Act and its Implementing Rules and Regulations to a socio-legal analysis. In the process, it becomes apparent that, contrary to the general trend, the law adheres to a decidedly hierarchical form of contracting, which is in a certain state of tension with the network-like organization it promotes and the use of contracting to realize development-oriented goals. To effectively implement the law's contracting concept, the authors suggest underpinning it with a more relational approach, a stronger management orientation of the executing entities, and the development of appropriate network governance concepts.

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A. Introduction

The Philippine law on universal health care (UHC), passed as Republic Act (RA) 11223 on February 2019,[1] is possibly one of the most recent legislative enactments since the World Health Organization's (WHO) call for universal health coverage in 2004. Popularly known as the UHC Act, it seeks to bring about comprehensive, more affordable, quality, and cost-effective care for all Filipinos and a nationwide coverage of the population. Building on

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1 Available at https://lawphil.net/statutes/repacts/ra2019/ra_11223_2019.html (last accessed on 19 February 2021).

earlier initiatives to introduce UHC, it substantially reshapes today's health sector, in particular, by providing for an extended financing program, new organizational structures for the sub-national health systems, and the introduction of health care provider networks. It also elevates contracting to the sole mechanism of health care delivery, thereby making the latest contribution to the 40-year debate on the use of contracting for this purpose.

The UHC Act is a law *designed for gradual implementation*. Externally imposed rather than internally generated, it borrows mainly from the UK National Health System, China's model of devolved health service provision, and experience with service delivery networks (SDN) in US-influenced health systems.[2] There has been very limited disclosure and public discussion of the concepts underlying the law, and the uncertainty associated with its implementation is high, especially in the private sector.[3] Moreover, some of its key innovations have not yet been explored in terms of alternatives or tested on a larger scale in the Philippine context. Instead, according to its Sec. 3 (General Objectives), the Act is geared to "progressively implementing UHC", for which it provides various transition periods ranging from 3 to 10 years. Its Implementing Rules and Regulations (IRR)[4] state in Rule 41.1.b.i. that baseline studies shall be carried out and operational guidelines established in the first of the three implementation phases for the integration of the sub-national health systems. In line with this development-oriented approach, it was only in September 2019 that the Department of Health designated the first pilot areas for such integration.[5]

As one of its major innovations, the Act stipulates that all individual-based health services shall be contracted by the Philippine Health Insurance Corporation (PhilHealth), a government owned and controlled corporation in operation since 1995, and all population-based health services by the Department of Health (DOH). Despite this important role, just one of the 45 paragraphs of the Act deals with contracting, and even here only with regard to some of its aspects. Again, neither the authors of the law nor the government have indicated what the specific features of contracting should be and what it is supposed to contribute to achieving the underlying health policy objectives. No preparatory studies on different forms of contracting have been conducted either, as has been done extensively in Cambodia, for example.[6] Therefore, it is possible that PhilHealth's current practice of contract use will be continued, as well as that it will be redirected in the course of the Act's

2 WHO, Representative Office for the Philippines, UHC Act in the Philippines: a new dawn for health care, 2019, https://www.who.int/philippines/news/feature-stories/detail/uhc-act-in-the-philippines-a-new-dawn-for-health-care (last accessed on 20 January 2021).

3 *Denise A. Valdez*, At the dawn of UHC, private hospitals brace for long struggle, BusinessWorld January 20, 2020, https://www.bworldonline.com/at-the-dawn-of-uhc-private-hospitals-brace-for-long-struggle/ (last accessed on 18 February 2021).

4 Available at https://www.philhealth.gov.ph/about_us/UHC-IRR_Signed.pdf (last accessed on 19 February 2021).

5 *WHO*, note. 2.

6 *Robert Soeters* and *Fred Griffiths*, Improving government health services through contract management: A case from Cambodia, Health Policy and Planning 18 (2003), pp. 74-83.

implementation due to the new objectives and changed framework conditions. Such a pragmatic approach is in line with a 2008 ADB report on contracting of providers by PhilHealth, which recommended "just do contracting and learn by doing, i.e. gradually expand and adjust the contracting mechanisms".[7]

The present paper examines the role and possibilities of contracting as a mechanism for the realization of health policy goals and the management of health service delivery under the new law. One of its *purposes* is to support the implementation of the UHC Act by identifying the contracting concept underlying the Act and exploring in which respects this concept needs adaptation in view of the prevailing circumstances. The second purpose is to contribute to the general discussion on contracting as a means of ensuring public health care, as there is little reliable knowledge about its working depending on particular conditions of use. To realize these intentions, the Act and its IRR are subjected to a socio-legal analysis in light of the situation in the Philippine health sector. For the analysis of a law, this methodological approach seems to be the most appropriate to consider the multiple political, social, economic, and legal aspects from a unified rather than a discipline-specific perspective.

B. Contracting for Health Services and the Philippine Experience

I. Contracting for Health Services

The *concept of contracting* relevant to the public sector and considered here was developed in the 1980s as part of the New Public Management (NPM) movement and is discussed today under the broader topic of 'government by contract'.[8] Geared towards the optimization of public services, it reflects two key principles of NPM: the separation of the roles of public purchaser and public provider, and competition between providers.[9] Both result in a planned and supervised market, also called quasi-market, in which government directive and elements of market discipline are combined. In such a context, contracting is expected to achieve 'value for money' in the provision of public services, while the achievement of equity goals is ensured to a greater extent than the free market can do. In quasi-markets, the public purchaser enters into an agreement with the provider on the nature and scope of the

7 *Jan Bultman, Ron Hendriks, Mary A. Evangelista, Blesilda Gutierrez, B., Alvin Marcelo* and *Rowena Daroy-Morales*, Philippines: Developing capacity for contracting of providers by PhilHealth, ADB Technical Assistance Consultant's Report, n.p. 2008, p. 9, https://doh.gov.ph/sites/default/files/publications/DevelopingCapacityContractingProvidersPhilHealth.pdf (last accessed on 19 February 2021).

8 *Hugh Collins*, Regulating Contracts, Oxford 1999, pp. 303 ff.; *Phillip J. Cooper*, Governing by contract: Challenges and opportunities for public managers, Washington, D.C. 2003; *Anne C. L. Davies*, Accountability: A Public Law Analysis of Government by Contract, Oxford 2001; *Peter Vincent-Jones*, The New Public Contracting: Public Versus Private Ordering?, Indiana Journal of Global Legal Studies 14 (2007), pp. 14 ff.

9 *Davies*, note 8, pp. 28 ff.

services to be delivered, the performance standards to be met, and the price, so that service provision can be monitored, measured, and remunerated accordingly.[10] This is expected to enhance the transparency of government activities and to establish accountability of the implementing units for expenditure and service execution. Contractualization in the health sector, however, also has its pitfalls, such as significant transaction costs, loss of service quality, inequities in health service delivery, and fragmentation of the health system.[11] In all this, it should be noted that government contracts must not be equated with private sector contracts, of which they merely adopt more or less elements. For example, contracts with public providers cannot be enforced in court in the same way as ordinary commercial contracts, which is why sometimes they are referred to as quasi-contracts or fictional contracts.[12] Their function, thus, is not to hedge performance promises, but to get the parties to articulate their requirements and discover their costs.[13]

Contracting for health services is in widespread use today and shows a variety of forms in terms of approach,[14] private sector and NGO involvement, type and scope of the services delivered,[15] and the form in which it is executed.[16] While in some areas of the public sector contracting has undoubtedly achieved its goal of generating efficiency gains, it is difficult to demonstrate its success for the health sector.[17] All in all, there is little knowledge and

10 *Collins*, note 8, p. 303.

11 *Benjamin Loevinsohn* and *April Harding*, Buying results? Contracting for health service delivery in developing countries, Lancet 366 (2005), p. 676; *Natasha Palmer, Lesley Strong, Abdul Wali* and *Egbert Sondorp*, Contracting out health services in fragile states, BMJ 332 (2006), p. 720, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1410853/ (last accessed 3 April 2021; *Collins*, note 8, pp. 312 ff.; *Xingzhu Liu, David Hotchkiss, Sujata Bose, Ricardo Bitran* and *Ursula Giedion*, Contracting for Primary Health Services: Evidence on Its Effects and Framework for Evaluation, Bethesda, MD 2004, pp. 7 f., https://www.who.int/management/resources/finances/ContractingPrimaryHealtServicesEvidence.pdf (last accessed on 20 January 2021).

12 *Collins*, note 8, pp. 315, 318; *Peter Spurcheon, Paula Smith, Mary Straker, Nicholas Deakin, Neil Thomas* and *Kieron Walsh*, The Experience of Contracting in Health Care, in: Rob Flynn and Gareth Williams (eds), Contracting for Health: Quasi-Markets and the National Health Service, Oxford 1997, p. 143.

13 *Collins*, note 8, p. 318; *Spurcheon et al*., note 12, p. 137 refer to it as „purely internal documents".

14 *Jean Perrot*, Different approaches to contracting in health systems, Bulletin of the World Health Organization 84 (2006), pp. 859-866.

15 *Loevinsohn* and *Harding*, note 11, pp. 676-681.

16 *Rob Flynn* and *Gareth Williams*, Contracting for Health, in: Rob Flynn and Gareth Williams (eds), note 12, p. 10.

17 *Keith Dowding* and *Peter John*, The Value of Choice in Public Policy, Public Administration 87 (2008), p. 223.

considerable disagreement about whether contracting,[18] purchaser-provider splits,[19] or quasi-market organization[20] are useful for the provision of health services, and this is all the more true for low- or middle-income countries.[21] Nevertheless, there is some evidence, admittedly limited to cases of outsourcing to the private sector, that contracting, despite its primary focus on increasing efficiency, need not have a negative impact on equity objectives[22] and may even contribute to their realization.[23]

II. The Philippine Experiences in Health Care Contracting

In the Philippine health care sector, 'contracting' developed over a period of more than 20 years from an accreditation mechanism to a purchasing instrument that is even used for active purchasing in one area. As of 1997, health care providers required an *accreditation* by PhilHealth in addition to the licenses granted by the DOH to be eligible for national health insurance (NHI) reimbursements. To this end, PhilHealth has been concluding agreements with health care providers via warranties of accreditation to secure quality and reliability of the services,[24] which is why *Picazo et al.*[25] in their study on purchasing of health services in the Philippines equate accreditation with contracting. PhilHealth, however, has always ac-

18 *Natascha Palmer*, The use of private-sector contracts for primary health care: theory, evidence and lessons for low-and middle-income countries, Bulletin of the World Health Organization 78 (2000), pp. 821-829; *Gareth Williams* and *Rob Flynn*, Health-Care Contracting and Social Sciences: Issues in Theory and Practice, in: Rob Flynn and Gareth Williams (eds), note 12, pp. 155 ff.; *Liu et al.*, note 11, p. xiv.

19 *Adam Wagstaff*, Social Health Insurance Re-Examined, Health Economics 19 (2010), p. 513.

20 *Pauline Allen*, An economic analysis of the limits of market based reforms in the English NHS, BMC Health Service Research 13 (2013), pp. 1-10; *Peter Vincent-Jones*, Contractual Governance: Institutional and Organizational Analysis, Oxford Journal of Legal Studies 20 (2000), p. 343.

21 *Palmer*, note 18, p. 822; *Anne Mills*, To contract or not to contract? Issues for low and middle income countries, Health Policy and Planning 13 (1998), pp. 32-40; *Liu et al*., note 11, pp. 1 ff.

22 *Liu et al*., note 11, pp. 1 ff.; *Benjamin Loevinsohn*, Performance-based contracting for health services in developing countries: a toolkit, IBRD/The World Bank, Washington D.C. 2008, https://www.who.int/management/resources/finances/CoverSection1.pdf. (last accessed on 14 January 2021).

23 *Indu Bhushan, Sheryl Keller* and *Brad Schwartz*, Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia, ADB, ERD Policy Brief Series No. 6, Manila 2002, https://www.adb.org/sites/default/files/publication/28064/pb006.pdf. (last accessed on 14 January 2021).

24 On this and the following see *Manuel M. Dayrit, Liezel P. Lagrada, Oscar F. Picazo, Melahi C. Pons* and *Mario C. Villaverde*, The Philippines Health System Review, Health Systems in Transition 8 (2018), p. 109.; *Oscar F. Picazo, Valerie G.T. Ulep, Gilbert, Ida M. Pantig* and *Beverly L. Ho*, A critical analysis of purchasing of health services in the Philippines: A case study of PhilHealth, Philippine Institute for Development Studies, Quezon City 2015, pp. 29 ff., https://dirp3.pids.gov.ph/websitecms/CDN/PUBLICATIONS/pidsdps1554.pdf (last accessed on 19 February 2021).

25 *Picazo et al*., note 24, pp. 29 f.

credited only a part of the licensed facilities, which made it even more difficult for the rural population to access its programs. In order to reduce redundancies, licensing and accreditation were merged in 2012 in such a way that all DOH-licensed facilities are now deemed to be accredited upon submission of certain documentation. The new law does not change this situation, so that licensing remains the main preventive approval procedure, albeit based on a mere compilation of documents and input checklists.

Under the past accreditation regimes, *purchasing* was largely passive.[26] An ABD/GTZ report[27] on the development of a system of contracting for PhilHealth refers to contracting as "a purchasing mechanism used to acquire a specified service, of a defined quantity […] and quality at an agreed-on price" and thus equates it with purchasing without further ado. It is in line with this wording that the law now defines contracting in Rule 4.7. IRR. In their practical application, health service contracts serve primarily to establish performance requirements and are poorly monitored and rarely enforced.[28] The aforementioned ABD/GTZ report accordingly states that the potential inherent in contracting is not fully realized.[29] A strategy of active purchasing is currently pursued only for the Z-benefits program,[30] a scheme for cases of catastrophic illness targeting the poor. For this, PhilHealth actively seeks capable providers with whom it makes agreements based on pre-established guidelines, quality standards, and cost calculations of the packages.[31] Discrete contracts are used, and providers have little room for negotiation.[32] As the program is small in scale,[33] experience with active purchasing is limited and restricted to PhilHealth and a few tertiary facilities. It involves highly specialized services, which by their very nature require a selection of providers, so that no conclusions can be drawn about the attitude towards active purchasing in general.

C. The Contracting Concept of the UHC Act

The UHC Act reshuffles the Philippine health care system by stipulating that after a transition period, all public health services must be contracted by the DOH and PhilHealth. But contracting is not only a way to organize the purchase of services, it is also an element that determines the institutional environment of health care provision. Given the variety of ap-

26 *Id*, p. 30.

27 *Bultman et al*., note 7, p. 15.

28 *Dayrit et al.*, note 24, pp. 112, 264.

29 *Bultman et al*., note 7, p. 13.

30 *Maria C. G. Bautista*, The PhilHealth Case—Health Care Contracts and Social Contract in Social Health Insurance, in: Ralph Schuhmann and Bert Eichhorn (eds), Contractual Management: Managing Through Contracts, Berlin 2020, pp. 350, 356 ff.

31 *Picazo et al*., note 24, p. 30.

32 *Bautista*, note 30, p. 359.

33 In 2015, it covered 2,031 patients; cf. *Dayrit et al.,* note 24, p. 109.

proaches and their far-reaching implications, *Perrot*[34] has pointed out that in-depth studies are needed before deciding on an appropriate contracting strategy. This has not happened in the Philippines. Since the political statements and the legislative procedure do not give any indication of how contracting is to be applied and in what way it is to contribute to the achievement of the reform goals, the Act and its IRR will be analyzed below with regard to the underlying concept of contracting in order to provide a basis for considering how it can be implemented in a purposeful manner.

The frame of reference for the following study is the *contractual governance approach*, which seems best suited for the socio-legal analysis of the contacting concept of an already enacted law. Drawing on *Williamson's* seminal article on the governance of contractual relations[35], it is increasingly accepted in socio-legal scholarship, and *Zumbansen*[36] has highlighted its special aptitude to describe the complex nature of contractual arrangements in the multipolar regulatory context of state and market. According to *Möslein and Riesenhuber*[37] it is particularly suitable to capture the mechanisms of steering through contracts as well as the framework of human interaction, and *Vincent-Jones*[38] has applied it for an institutional and organizational analysis of contracting in the context of market, quasi-market, and social relations. What is new about the present study is that it uses this approach to study a law that has already been enacted. In order to identify the underlying contracting concept, the relevant legal regulations are examined first in terms of the form of social organization and then with regard to the main objectives of the reform.

I. The Underlying Form of Social Organization

The form of social organization of health care determines the institutional framework for service contracting. Sociology[39] distinguishes three manifestations in this respect – hierar-

34 *Perrot*, note 14, p. 863.

35 *Oliver E. Williamson*, Transaction-Cost Economics: The Governance of Contractual Relations, The Journal of Law & Economics 22 (1979), pp. 233-261.

36 *Peter Zumbansen*, The Law of Society: Governance Through Contract, Indiana Journal of Global Legal Studies 14 (2007), pp. 191-233.

37 *Florian Möslein* and *Karl Riesenhuber*, Contract Governance – A Draft Research Agenda, European Review of Contract Law 5 (2009), pp. 248-289.

38 *Vincent-Jones,* note 20, pp. 317-351.

39 Starting with *Oliver E. Williamson*, a corresponding discussion is also taking place in economics under the keyword 'hybrids'; cf. *Claude Ménard*, The Economics of Hybrid Organizations, Journal of Institutional and Theoretical Economics 160 (2004), pp. 345-376; *Wolfgang Seibel*, Studying Hybrids: Sectors and Mechanisms, Organization Studies 36 (2015), pp. 697-712. In light of the policy goals of the UHC Act and its more frequent use for health services analysis, the sociological approach is preferred here.

chy, market, and network[40] – whereby the focus of interest today is on hybrid arrangements and less on the ideal types.[41] Initially, a developmental progression from hierarchy to market and then possibly to networks was assumed,[42] but in view of disappointing results of provider networks, hierarchical forms of health service organization are now experiencing a certain renaissance.[43] The ideal types are each accompanied by specific coordination patterns or governance styles.[44] A qualification of the form of organization underlying the UHC Act thus allows conclusions to be drawn with regard to the deployment of contracting and the respective style of governance.

a) *Hierarchies* are characterized by authoritarian decision-making, also referred to as command-and-control style, and can be found in both the public and private sectors. *Stinchcombe*[45] has shown that contracts can be used to build hierarchical elements into the party relationship when there are difficulties in specifying the services, estimating the costs, or measuring the contractor's performance, conditions that also feature health services. Such elements are, in particular, command structures, incentive systems, standard operating procedures, and internal dispute resolution procedures. If contracts are used to describe relationships between parts of the governmental organization, or public agencies have monop-

40 *Grahame F. Thompson*, Between Hierarchies and Markets: The Logic and Limits of Network Forms of Organization, Oxford 2003, pp. 1 ff.; *Joel M. Podolny* and *Karen L. Page*, Network Forms of Organization, Annual Review of Sociology 24 (1998), pp. 57 ff.

41 *Martin Powell* and *Michele Castelli*, "Strange animals": hybrid organisations in health care, Journal of Health Organization and Management 31, (2017), pp. 1 ff.; *Eugene Bardach*, Networks, Hierarchies, and Hybrids, International Public Management Journal 20 (2017), pp. 560-585; *Tim Tembensel*, Bridging complexity theory and hierarchies, markets, networks, communities: a 'population genetics' framework for understanding institutional change from within, Public Management Review 20 (2018), pp. 1032-1051, reprint accessible at ResearchGate, p. 3 (last accessed on 25 January 2021).

42 *Tembensel*, note 41, pp. 2 f.; *Toby Greany* and *Rob Higham*, Hierarchy, Markets and Networks: Analysing the 'self-improving school-led system' agenda in England and the implications for schools, London 2018, p. 26, https://discovery.ucl.ac.uk/id/eprint/10053501/1/Hierarchy%20Markets%20and%20Networks%20FINAL.pdf (last accessed on 19 February 2021).

43 *M. Ramesh, Xun Wu* and *Michael Howlett*, Second Best Governance? Governments and Governance in the Imperfect World of Health Care Delivery in China, India and Thailand in Comparative Perspective, Journal of Comparative Policy Analysis: Research and Practice, Policy and Society 34 (2015), pp. 342-358.

44 *Ewan Ferlie, Louise Fitzgerald, Gerry McGivern, Sue Dopson* and *Max Exworthy*, Networks in Health Care: a Comparative Study of Their Management, Impact and Performance, Report for the National Institute for Health Research Service Delivery and Organisation programme, London 2010, p. 13, https://www.academia.edu/3256179/Networks_in_health_care_A_comparative_study_of_their_management_impact_and_performance (last access on 19 January, 2021); *Tom Entwistle, Gillian Bristow, Frances Hines, Sophie Donaldson* and *Steve Martin*, The Dysfunctions of Markets, Hierarchies and Networks in the Meta-governance of Partnership, Urban Studies 44 (2018), pp. 64 f.

45 *Arthur L. Stinchcombe*, Information and Organizations, Berkeley 1990, pp. 223 ff.

sony power, contracts rely heavily on such hierarchical elements. They enable public purchasers to determine standards and specify procedures, as was previously done through administrative regulations, circulars, and notices.[46] Since the public authority sets the conditions and the supplier is left with no room to negotiate, contracting just becomes a form in which an administrative relationship is expressed, and the term 'contract' is a mere metaphor.[47] So when *Palmer*[48] states that heavy regulation compromises contracting, it requires the caveat that this only applies if the contract is used with functions comparable to those in the private sector.

The UHC Act refers to a distinctly *hierarchical approach* by ensuring tight executive control on the performance of the provider through the purchasing agencies within a general planning competence of national government. Pursuant to its Sec. 18, provider networks shall be contracted under the condition that they agree to service quality, co-payment/co-insurance, data submission standards, and the payment schemes as determined by PhilHealth. This confronts the provider with a 'take it or leave it' situation as far as some of the core objectives of the reform are concerned, namely, to improve the quality, protect the indigents and enable authorities to access health data.[49] Professional associations are only weakly involved in these regulatory processes,[50] and NGOs, patient or other civil society organizations are not even mentioned in the law. The comprehensive standard-setting power of the purchasers is accompanied by "strong surveillance and audit mechanisms to ensure network's compliance to the contractual obligations"[51] and backed by extensive sanctioning instruments. It is indicative that of the 12 times, the terms 'contract' and 'contracting' appear in the law, this happens 6 times in the chapter on penal provisions. Moreover, under Rule 18.6. IRR, contracted networks and their members are subjected to PhilHealth's quasi-judicial powers, so that the purchaser can decide on matters that affect itself. Overall, then, the Act concentrates decision competencies in the purchasing agencies and instrumentalizes the contract to extend the government's regulatory power via these agencies into the service relationships.

Only in two places do the IRR follow a more *market-oriented approach* and address the contract as a means of regulation rather than as an object of regulation. In Rule 19.3. it stipulates that the private sector shall be encouraged "through a contractual arrangement" to participate in the local health systems. This is in line with a statement made in the 2018

46 On this and the following cf. *Collins*, note 8, pp. 303 ff.; *Vincent-Jones,* note 20, pp. 326 ff.

47 *Collins*, note 8, p. 303.

48 *Palmer*, note 18, p. 824.

49 Quality assurance and data collection were also identified as key contracting objectives for the National Health Service (NHS) in the UK in the 1990s; cf. *Rob Flynn, Gareth Williams* and *Susan Pickard*, Quasi-Markets and Quasi-Trust: The Social Construction of Contracts for Community Health Services, in: Rob Flynn and Gareth Williams (eds), note 12, p. 61.

50 The only reference is Rule 40.1.d. IRR.

51 Sec. 18 (b) UHC Act.

WHO Philippine Health System Review[52], that private sector participation in the provision of health services requires that the existing strong command-and-control mechanisms be complemented by incentives. In Rule 36.5., the IRR further spells out that PhilHealth shall "use its contracts to incentivize the incorporation of health information systems". Both provisions indicate that the authors of the law were aware of the contract's capacity to actively ensure the achievement of specific health care objectives, but deliberately chose not to use it for contracting in general.

b) *Market organisation* builds on price or a price-performance mix and relies on the contract as a crucial coordination mechanism.[53] Transferred to the public sector, this form of organization integrates elements of market discipline into the bureaucratic system, leading to a hybrid form of market and hierarchy.[54] Such planned markets or quasi-markets are not fully competitive, but incentivize behaviour for desired outcomes.

The Philippines has a mixed health care system with a largely market-oriented private sector and a public sector that, to some extent, exhibits the features of a quasi-market, which are usually seen in a multiplicity of providers and purchasers, competition, and consumer choice.[55] The UHC Act impacts these features in several places:

- The *separation of the roles* of purchaser and provider was initiated in 1991 through a massive decentralisation programme, driven forward by the creation of PhilHealth in 1995 and is now completed with transition to comprehensive contracting.
- *Competition* in the public health sector is weak. This is partly in the nature of the industry, as providers have assigned catchment areas, but partly also due to specific domestic circumstances. These include a "glaring shortage" of health professionals,[56] non-mandatory private sector participation, and a considerable decrease in provider density from urban to rural areas, which are frequently underserved or unserved. The UHC Act does not fundamentally address this situation. With regard to the supply of remote areas and the participation of private providers in health care networks, it mandates at least the establishment of corresponding incentive systems. But as will be shown, financial support for the private sector is short-term and subject to narrow conditions, and the persistence of tax-based full funding of public facilities is likely to undermine the motivational effects that incentive schemes and performance-based payments can have on them.
- In Sec. 6 (c) the Act assigns the primary care provider a gatekeeping role for access to secondary and tertiary care, eliminating the patients' previous freedom to choose the fa-

52 *Dayrit et al.*, note 24, pp. xxviii, 270.

53 *Jan-Eric Lane*, New Public Management, London 2000, pp. 147, 159; for the UK's HNS, cf. *Allen*, note 20, p. 7.

54 *Vincent-Jones*, note 20, p. 326.

55 *Id.*, p. 341.

56 The DOH refers to a 50% to 60% gap for some types of facilities in 2003 that essentially persists to this day; cf. *DOH*, Health Policy Notes 6 (2009), pp. 4, 7, https://doh.gov.ph/sites/default/files/publications/Vol6Issue3November2009_0.pdf (last accessed on 16 January 2021).

cility themselves. In line with the quasi-market concept, this right of choice will be exercised by PhilHealth in the future when awarding contracts – provided that the limited competition offers a choice. Whereas a feedback mechanism for patients is prescribed in Rule 40.1.d. IRR, the law does not address the participation of the general public or the patients' representatives, what is considered a crucial condition for the assimilation of a market mechanism for the provision of public services.[57]

Thus, a fundamental and programmatic strengthening of the market elements by the law is not discernible.

c) Unlike for the market elements, the law significantly strengthens *network organization* for the provision of health care in two respects. Firstly, it integrates the local health systems into the province-wide and city-wide health systems. These newly formed networks are allocated special health funds, through which all resources earmarked for service delivery are pooled and managed. Secondly, the Act provides that after a transitional period and with a possible exception for apex or end-referral hospitals, health care provider networks will be the sole providers reimbursable under the NHI system. In the Philippines, the concept of Service Delivery Networks (SDNs) has been adopted by several governmental instruments and tested for health services in different contexts,[58] albeit mostly under technical and functional aspects. In various provisions,[59] the law outlines the nature and role of the envisioned health care provider networks, specifying *inter alia* that they must have a legal personality, engage in contractual arrangements with the purchasers, provide the services, maintain mechanisms of pooled fund management, and will be monitored with regard to compliance with their obligations. The network members, in turn, are obliged to execute or sign performance contracts with the purchasers and are subjected to rating, incentive and sanction systems. This complex texture is underpinned by a network of formal contracts that includes the network's contracts with the purchasers, the performance contracts between PhilHealth and the network members, and the articles of association of the network.

A network organization typically requires a corresponding *style of governance*, characterized by high levels of trust, informal contact, and negotiation,[60] which stands in marked contrast to the hierarchical approach of the law and the bureaucratic way the Philippine public sector operates. For the governance approach to health service delivery in general, it must be noted that the authors of the law still considered a hierarchical-coordinative style to

57 *Collins*, note 8, pp. 305 ff.

58 Jhpiego Philippines, Guide in Establishing a Functional Service Delivery Network (SDN) for MNCHN-FP Services, Manila 2016, pp. 1-144; *Hilton Y. Lam, Roberto de Vera, Adovich S. Rivera, Tyrone Reden Sy, Kent Jason G. Cheng, Daryl Byte Farrales, Jaifred Christian F. Lopez* and *Red Thaddeus D. P. Miguel*, Describing the Health Service Delivery Network of an Urban Poor Area and a Rural Poor Area, Acta Medica Philippina 52 (2018), pp. 438-446.

59 Sec. 17, 18, 27 (a), 38 (c) UHC Act and Rule 18.4.f. IRR.

60 *Ferlie et al*., note 44, p. 13.

be expedient and did not follow the current general trend towards partnership or competition.[61]

II. Alignment of Contracting with the Act's Reform Objectives

The UHC Act states in Sec. 3 its two main objectives: 1) to create the organizational conditions for the progressive realization of universal health care and 2) to provide citizens with equitable access to quality and affordable health goods and services. Considering the situation in the Philippines, *Dayrit*[62] identifies four challenges that the new law must address: ensuring equitable access and inclusion, reducing out-of-pocket payments (OOPs), improving the quality of services, and synergizing the activities of the public and private health sectors. A closer look at the role the law assigns to contracting in dealing with these issues can provide further insight into the underlying concept.

a) The first two challenges correspond to one of the core objectives of the reform to expand health care coverage for *disadvantaged groups*, i.e. people living in remote areas and the indigents. To this end, the law relies primarily on expanded funding, but also on contracting. With regard to the underserved areas, Sec. 29 (a) UHC Act provides for "preferential licensing of health facilities and contracting of health services". While preferential licensing is described in more detail in Rules 29.1. to 29.4. IRR, there are no corresponding provisions for preferential contracting, which gives the purchasing agencies a wide discretion in this respect. To improve access for indigents, Rule 18.2.b. IRR mandates that each provider network must agree to co-payment guidelines as a condition for the award of the contract. It is, thus, rolling out an approach that has so far only been applied to government hospitals with regard to sponsored members.[63] The co-payment guidelines specify the services that are permitted to be billed outside of PhilHealth benefits and that patients may then have to pay for themselves. With PhilHealth covering, on average, only 30-50% of facility bills, whether public or private, patients have to pay extra for virtually everything,[64] and OPPs are extraordinarily high by Asian standards, accounting for 52% of national health expenditure. A moderate reduction of OOPs is part of the National Objectives for Health, which also provide for the instrument of co-payment limitation for “contracted hospitals” to this

61 *Perrot*, note 14, p. 862.

62 *Manuel M. Dayrit*, Our country’s quest for universal health care, Business World, March 27, 2019, https://www.bworldonline.com/our-countrys-quest-for-universal-health-care/ (last accessed on 19 February 2021).

63 *Dayrit et al*., note 24, p.107.

64 *Sulakshana Nandi, Ana Vračar* and *Chhaya Pachauli*, Resisting privatisation and marketisation of health care: People’s Health Movement’s experiences from India, Philippines and Europe, Saudé Debate 44 (2020), p. 42.

end.[65] The implementation of the guidelines, however, will prove challenging given patient ignorance, underdeveloped monitoring capabilities and, arguably, often a lack of the will to enforce.[66] It is significant that the law addresses implementation only in Rule 38.7. IRR, which qualifies non-compliance with the policy on co-payment as an offense. On the whole, the law assigns contracting an extremely vague role in terms of service delivery in remote areas and no substantive role for the inclusion of the poor.

b) The provision of *quality health goods and services* represents another challenge of the reform, and contracting is linked to its achievement in three ways. Firstly, the introduction of comprehensive contracting in combination with the expansion of public health care financing will increase PhilHealth's buying power and thereby provide it with a stronger position to control quality. So far, it has not been a strategic purchaser due to its small share in total health expenditures.[67] Secondly, PhilHealth regains, in part, the active control over access to its benefit programs that it was previously able to exercise with respect to provider quality and reliability through accreditation. Thirdly, it is granted wide-ranging powers to set and enforce contractual quality requirements. This formally strong position, however, must be put into perspective on closer examination. The pronounced hierarchical style of coordination implies a high-level service specification, rigid performance control, and consistent sanctioning, which require distinctly discrete contracts, i.e. agreements that are very detailed, inflexible and detached from the specifics of the relationship. Many problems in health care contracting, however, are attributed to artificially discrete contracts,[68] as a comprehensive definition of a standard service cannot be achieved due to the complex nature of health care,[69] and detailed specifications conflict with the requirements of clinical control, professional discretion, and professional ethics. Discrete contracts also need consistent follow-up, which is still a long way to go in the Philippines,[70] where monitoring, if it is done at all, is performed manually on the basis of inspection visits and hard-copies. Many experts, therefore, suggest that contracting be avoided if tight monitoring processes cannot be put in place. Despite PhilHealth's legally strong position to contractually implement its quality requirements, actual realization will, thus, remain a challenge.

c) The fourth challenge identified by *Dayrit* is to increase the involvement of the *private sector* in public health care. In the Philippines, this sector comprises nearly two-thirds of all

65 *Department of Health*, National objectives for health: Philippines 2017-2022*,* Manila 2018, p. 35, https://doh.gov.ph/node/16880 (last accessed on 3 January 2021).

66 *Bultman et al*., note 7, p. 8.

67 *Dayrit et al.*, note 24, p. xxiii.

68 *Vincent-Jones*, note 20, p. 342.

69 *Williams* and *Flynn*, note 18, pp. 154 ff.

70 *Dayrit et al.*, note 24, e.g. p. 114. In many places, the authors point to inadequate monitoring as an overarching problem.

providers, is largely market-based, and follows the US-American ethos. Since the 1970s, health policies of almost all governments have provided for forms of privatization[71] that have strengthened the private sector beyond its considerable entrepreneurial growth. Private facilities are mostly found in the more densely populated areas, provide better quality, and demand higher payments. This is why they are primarily frequented by those who can afford it, namely employees with private health insurance on top of their PhilHealth coverage and those who are better-off. As a result, the private health sector is largely isolated from the public health sector in geographical, social, and informational terms.

The new law perpetuates rather than softens this compartmentalization by not addressing the specific situation of private providers and subjecting them almost entirely to the same regime as their public counterparts. Only in one provision, Rule 19.3. IRR, does it make an exception to this and provides that the "private sector shall be encouraged […] through a contractual arrangement" to participate in the integrated local health system, without, however, elaborating on what this "encouragement" should look like. More importantly, it limits the scope of application to publicly-led networks and to services that complement those of the public providers, and to that extent excludes public-private competition. Of the general regulations applicable to both public and private providers, two sets of provisions are as significant for the present context as they are characteristic for the reform approach. Rules 18.8. and 41.6. IRR mandate "licensing and contracting incentives for contracted health care facilities to form health care provider networks" and thereby respond to the conclusion of a WHO study on the Philippine health sector[72] that a functioning system of service networks will depend on the full support and active participation of the private sector. The rules, however, do not address the particularities of private providers and limit the benefits to a period of three years from the enactment of the IRR. The second set of provisions, Rule 18.2.b. IRR, stipulates that bidders must submit to fixed co-payments as a condition for the award of the contract, thus reducing the attractiveness for private providers who could previously set their own prices.[73] Contrary to the trend to consider contracting primarily in terms of outsourcing to the private sector, the UHC Act deals with it mainly with regard to the public sector and gives only half-hearted impetus to private sector participation.

D. Development Needs Regarding the UHC Act's Contracting Concept

The UHC Act mentions aspects of contracting for individual-based health services only in Sec. 18, and even there very selectively. The authors of the law were obviously of the opinion that PhilHealth's previous procedure will also be expedient under the new conditions. This is supported by the fact that Rule 17.5. IRR mandates appropriate guidelines to be es-

71 *Nandi et al*., note 64, pp. 42 ff.

72 *Dayrit et al*., note 24, p. 270.

73 *Bultman et al*., note 7, p. 39; *Dayrit et al*., note 24, p. xxiv.

tablished for population-based health services by the DOH, while there is no corresponding regulation for individual-based health services. However, the changes in the organizational and institutional framework brought about by the Act and the role it assigns to contracting raise the question of whether and, if so, how PhilHealth's current practices need to be adapted. The preceding discussion highlights four issues that require closer consideration in this regard.

a) For contracting in general, the law follows a hierarchical approach and uses a more market-oriented concept only for two cases of contractual incentivization. Monetary and licensing incentives, however, are also coordination tools and, similar to a contract, entail binding commitments by the participants to behave in the manner promised. Not only can these *different instruments of coordination interact* in their actual application, but the law also combines them in some places:

- Reward for a better provider performance, Sec. 27 (a) UHC Act;
- Preferred licensing and contracting, Sec. 29 (a) UHC Act;
- Financial and licensing incentives to contracted facilities, Sec. 41 (f) UHC Act;
- Incentivization through contracts, Rules 19.3. and 36.5. IRR.

These combinations are used exclusively to promote the crucial development goals of the law: participation in networks, coverage of underserved areas, introduction of a Health Information System, private sector participation in local health systems, and improvement of the provider performance in particular with regard to quality.

The combination of such coordination tools leads to a linking of the different relationships a network or network member has with the various administrative units. This may cause spill-over effects from one relationship to the other, creating a further network, this time informal, that includes the purchasing agencies, the provider network, the facilities, and their various owners on the local, provincial, city or national level. These conditions place particular demands on the numerous administrative units involved, which must ensure effective coordination of their activities, both in terms of strategic planning of provider performance and party relationship, and in terms of operational activities such as monitoring, evaluation, and intervention. This requires effective process organization, communication, and willingness to cooperate. Likewise, the administrative units must adopt a consistent approach to relationship governance in order to prevent conflicting signals from being carried into the various relationships with a provider, which is especially true for the crucial parameters of trust and control. Depending on the scope and design of the incentive schemes and the involvement of the private sector, the need to depart from the hierarchical approach to contracting can therefore be much greater than the law would suggest at first glance.

b) To achieve its overall objective of extended health coverage, the UHC Act relies primarily on the provision of greater financial resources. However, experience shows that problems

in the supply of health services cannot be solved with money alone,[74] and the Covid-19 pandemic demonstrates also for the Philippines[75] that the financial situation of a public health insurance system and priorities in the allocation of resources can change rapidly. Since in a context of scarcity, *efficiency* becomes not only a political but also an ethical imperative,[76] contracting must also be geared towards ensuring the best possible use of available resources. This calls for adjustments to the institutional framework with the aim that contracting, in addition to its role as an instrument for coordinating health care provision, also assumes the function of managing service delivery, especially with regard to efficiency and quality requirements. To this end, it must be used not only to control the service providers' performance, but also to enhance their respective capabilities. The various substantive development targets set by the law and the incentive systems it provides are significant steps in this direction, but they must be accompanied by the promotion of a cooperative attitude on the part of both purchasers and providers and their willingness to engage in dialogue and negotiation.

c) The introduction of *health care provider networks* appears to be one of the sticking points of the reform. Since the internal relationships between network members as well as their and the network's external relationships with the purchasing agencies are based on formal contractual arrangements, the success of contracting will be tied to that of the network concept and *vice versa*. Networks in general, however, place particularly high demands on their management,[77] and although they are well established in many health systems, insights are scarce as to why so many of them fail.[78] Therefore, in addition to the functional and technical aspects that have already been tested to a certain extent in the Philippines, the focus needs to be placed on organizational and management issues. As it is particularly difficult to bring about accountability in networks,[79] a first step must be to clearly delineate the powers and responsibilities of the network from those of its members. Otherwise, one of the core objectives of introducing contracting, increasing transparency and accountability, may be thwarted. In a next step, these rights and duties must be harmonized in a consistent concept and underpinned with suitable processes. Finally, an approach to network governance needs to be elaborated that allows private providers to adequately promote their interests within the network and, in particular, to assess and manage their economic risk. In this

74 *Loevinsohn* and *Harding*, note 11, p. 676.

75 *Hannah Torregoza*, PhilHealth: Delay implementation of UHC Act, expansion of primary health care benefits, Manila Bulletin, 16 June 2020, https://mb.com.ph/2020/06/16/philhealth-delay-implementation-of-uhc-act-expansion-of-primary-health-care-benefits/ (last access on 6 January, 2021).

76 *Kasper Raus, Eric Mortier* and *Kristof Eeckloo*, Organizing Health Care Networks: Balancing Markets, Government and Civil Society, International Journal of Integrated Care 18 (2018), p. 3.

77 *Cooper*, note 8, p. 113 ff.; *Entwistle et al*., note 44, pp. 63 f.

78 *Raus et al.*, note 76, p. 1.

79 *Cooper*, note 8, p. 119 f.; *Entwistle et al*., note 44, p. 63.

context, it will be essential to explore how best to coordinate public and private network members in view of their different requirements, experiences, and attitudes.

d) Development tasks and the growing network organization pose challenges to contracting that go beyond the possibilities of a command-and-control style of coordination and rather require an opening towards *relationship governance and management approaches*. Even though there are indications that the suitability of contracts for managing quality and efficiency in health care should not be overestimated,[80] these only say something about the rationale and environment of contracting, but not about its possibilities *per se*. The contract is the central instrument for governing the relationship between the transaction partners, at least for complex transactions, such as those typical for health services. Relational contracting has shown that significantly better results are achieved in such settings when the relationship between the parties is based on trust, limited tendering, and long-term commitments. In the past, however, relations between PhilHealth and providers have often been strained and lacking in trust,[81] while the extensive devolution of public facilities has weakened the effectiveness of bureaucratic coordination mechanisms. The focus of contracting should therefore be shifted from service provision to the service relationship, with the main emphasis on institutionalizing dialogue and developing mutual appreciation.

Contracting's task of aligning provider performance with the development goals of the UHC Act and its role in the context of incentive schemes require an increased use of management techniques and a corresponding management mentality on the part of purchasers. There is little solid knowledge about the management of contracts and contracting processes for health services in low- and middle-income countries, but both topics are considered to be of greater importance.[82] Although public administration in the Philippines is characterized as being highly bureaucratic,[83] it is no stranger to management approaches.[84] Accordingly, Rule 41.4. IRR speaks of a public management approach to the integration of local health systems, strategic planning, managerial integration, procurement and supply

80 *Williams* and *Flynn*, note 18, pp. 155 ff.; *Collins*, note 8, p. 314.

81 *Dayrit et al.*, note 24, p. 83; *Wil M. Amazona*, 80 hospitals in Eastern Visayas under probe of alleged fraud, CNN Philippines, February 26, 2020, https://www.cnnphilippines.com/regional/2020/2/26/80-hospitals-Eastern-Visayas-under-probe-ghost-claims.html (last accessed on 19 February 2021). In November 2019, about 600 hospitals signalled their intention not to accredit with PhilHealth until their outstanding receivables are settled; cf. *Valdez*, note 3 (last accessed on 18 February 2021).

82 *Palmer*, note 18, p. 825; *Mills*, note 21, pp. 38 f.; *Soeters* and *Griffiths*, note 6, pp. 82 f.

83 *Alex Brilliantes* and *Maricel* Fernandez, Is There a Philippine Public Administration? Or Better Still, For Whom is Philippine Public Administration?, Philippine Journal of Public Administration 52 (2018), p. 246; *George Carmona*, NPM in the Philippines: A Query on How to Apply Principles to Reform Initiatives, Friedrich Naumann Foundation for Liberty, Philippine Office, Seminar Reports, 2006, http://www.fnf.org.ph/seminars/reports/npm-in-the-philippines.htm (last accessed on 19 February 2021).

84 *Carmona*, note 83.

chain management, and quality assurance. At least for development-oriented contracting, this suggests the use of management concepts, with a contract-based approach appearing particularly suitable for this purpose. *Bautista*[85] has demonstrated for the procurement of Z-benefits that the contractual management approach[86] can contribute significantly to the control of health service delivery, especially with regard to risk management and knowledge management. There is reason to believe that appropriate approaches to relationship governance and contract-based management can strongly support contracting in pursuing the reform objectives of the Act.

E. Conclusions

The Philippine UHC Act provides one of the most recent examples of contractualization of health services. While setting strong new accents with the expansion of funding, the integration of the subnational health systems, and the introduction of health care provider networks, the law maintains the existing features of public contracting. However, the excessive bureaucracy and the highly hierarchical governance approach conflict with the network organisation strengthened by the law and its recourse to contracting in the pursuit of development-oriented goals. In order for contracting to be able to fulfil the tasks assigned to it, its concept must therefore be aligned with the new organizational and institutional framework conditions. There are four starting points for this:

1. Establishment of network-like cooperation and communication mechanisms on the demand side to secure a consistent coordination of the relationships between the various administrative units and a provider network and its members.
2. Orientation of contracting towards efficient service provision by including elements of a development partnership in the contractual relationship.
3. Promotion of organizational, management, and governance concepts for service delivery networks, with special regard to the needs of private providers.
4. Development of the relationship dimension of contracting and a more managerial approach to handling contracts.

85 *Bautista*, note 30.

86 *Ralph Schuhmann* and *Bert Eichhorn*, From Contract Management to Contractual Management, European Review of Contract Law 11 (2015), pp. 1-21.