

Leveraging private sector primary care providers to increase access to family planning in the Philippines

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BREAKING NEW GROUND





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TABLE OF CONTENTS

Abbreviations..... 4
Executive Summary 5
I. Introduction and rationale 6
II. Methodology 10
III. Situation Analysis 10
IV. PhilHealth Purchasing of Family Planning 22
V. Midwife Perspectives on PhilHealth and Family Planning..... 28
VI. Discussion and Recommendations 34
VII. Conclusion..... 37
Glossary 38
References 40

ABBREVIATIONS

ANC	antenatal care
ASC	ambulatory surgical clinic
BTL	bilateral tubal ligation
DHS	Demographic and Health Survey
DOH	Department of Health
DOH-LTO	Department of Health License to Operate
DOH-PTC	Department of Health Permit to Construct
FPCBT	Family Planning Competency-Based Training
HCPNs	health care provider networks
HITP	health information technology provider
IMAP	Integrated Midwives Association of the Philippines
IRR	implementing rules and regulations (of the UHC Law)
IUDs	intrauterine devices
LARCs	long-acting and reversible contraceptives
LGU	local government unit
MCP	maternal care package
mCPR	modern contraceptive prevalence rate
MNCH	maternal, newborn, and child health
MOA	Memorandum of Agreement
MSD	Merck Sharpe & Dohme
NCIFP	National Composite Index on Family Planning
PHC	primary health care
PhilHealth	Philippine Health Insurance Corporation
PPIUD	postpartum intrauterine device
PRC	Professional Regulation Commission
RHUs	rural health units
RPRH	Responsible Parenthood and Reproductive Health Law
SDI	subdermal implant
SP4PHC	Strategic Purchasing for Primary Health Care
TFR	total fertility rate
UHC	universal health coverage

EXECUTIVE SUMMARY

Improving access to a choice of family planning methods in the Philippines is a key goal of the Strategic Purchasing for Primary Health Care (SP4PHC) project. Supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell, SP4PHC is a multi-country initiative to strengthen how governments purchase primary health care (PHC) services, with a focus on family planning and maternal, newborn, and child health (MNCH). In the Philippines, SP4PHC's work includes support to the Philippine Health Insurance Corporation (PhilHealth) in their efforts to use purchasing to encourage private providers to offer FP services.

The use of modern contraception in the Philippines is increasing steadily but is still very low compared to regional peers. Increased modern contraceptive prevalence rate (mCPR) is a key target of the Philippine government. Private providers, especially private midwives, are an important and trusted source of reproductive health services, but few offer family planning services. PhilHealth has introduced special contracting and payment mechanisms to encourage private providers to provide contraception, but has seen limited impact. Through policy review, data analysis, and qualitative methods, ThinkWell is working with PhilHealth to understand why this is, and to suggest solutions.

This report summarizes the team's findings. A situation analysis suggests that demand for family planning services outstrips supply and that private providers do indeed have capacity to fill a gap in the market. This is especially true for long-acting and reversible contraceptives (LARCs), which are underused in the Philippines, compared to regional peers. PhilHealth has high population coverage and an increasingly significant role in government health spending and is thus well positioned to influence the market for family planning services and to encourage private provider engagement.

A detailed review of PhilHealth processes relating to contracting providers and processing claims demonstrates the complexity of current systems, as it illustrates some potential challenges. An analysis of PhilHealth data highlights the disappointing performance in terms of providers engaged and claims paid.

Finally, a deep dive into midwife perceptions of PhilHealth family planning contracts identifies several important barriers to participation. Very high local market prices for contraceptives make PhilHealth reimbursement rates seem unprofitable to most private providers, and perceptions of delayed and uncertain payment further undermine financial incentives. A complex and time-consuming licensing and accreditation process deters many private midwives from contracting with PhilHealth at all. And finally, midwives in the Philippines may see offering family planning as being at odds with their professional identity.

SP4PHC is working with PhilHealth to develop and test solutions to these challenges. A major health sector reform triggered by the passing of the Universal Health Care (UHC) Law in early 2019 presents an opportunity to review and reconsider ways to engage private providers in PHC in the Philippines. ThinkWell is providing technical support to benefit package design and working with the Department of Health (DOH) and other stakeholders to consider responsibilities for procurement and supply of contraceptives. ThinkWell has been asked to support UHC integration sites, specifically to develop ways to engage private primary care providers in health care provider networks. These activities present opportunities to develop and test effective mechanisms for improving access to, and choice of, family planning.

I. INTRODUCTION AND RATIONALE

Health sector reform in the Philippines presents a critical opportunity to improve access to high-quality family planning services. The supply of family planning services has not kept up with demand in the rapidly evolving social context of the Philippines. Political commitment to improving access to family planning is high, and is reflected in policy and regulatory changes including a UHC Law that will radically reform the Philippines health sector in the coming years. This reform presents the opportunity to dramatically improve access to family planning by leveraging a vibrant private reproductive health sector that currently offers highly limited clinical family planning services. Contracting of private providers gives PhilHealth the potential to expand the number of family planning service delivery points, improve the quality of services, and increase the choice of family planning methods available at each site.

Improving access to a choice of family planning methods in the Philippines is a key goal of the SP4PHC project. SP4PHC is a multi-country project supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell. The project aims to improve how governments pay providers for PHC services, with a focus on family planning (FP) and MNCH. The project, which runs from 2017 to 2021, is implementing programs in Burkina Faso, Kenya, Indonesia, the Philippines, and Uganda. This document presents evidence generated in ThinkWell’s work in the Philippines, focusing on how PhilHealth can help improve access to family planning.

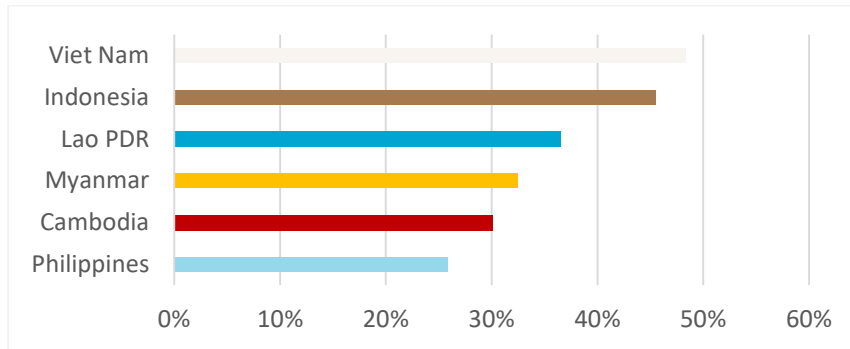


Figure 1. Percentage of all women aged 15-49 currently using a modern contraceptive method

Source: 2018 data from FP2020 (accessed June 2019). Countries selected as peers based on GDP / capita (at purchasing power parity) and Human Development Index (HDI) – Philippines has the highest HDI and the second highest GDP per capita in this group.

Few people in the Philippines use modern contraception to plan their families, and while demand is increasing, supply is limited. Figure 1 shows that mCPR for all women in the Philippines is much lower than in regional peers. Conservative social norms around contraception, associated with the important role of the Catholic church in the Philippines, are no doubt part of this story. However, surveys of Filipinos have reported increasing willingness to use contraception. As recently as 2003, 19.7% of Filipino non-users reported that they were not using contraception due to “opposition,” a category that includes religious or ethical objection. In 2008, the proportion was 9.6%, and special analysis of the 2013 Demographic and Health Survey shows only 1.6% opposition to family planning (National Statistics Office and ORC Macro 2004; National Statistics Office and ORC Macro 2019; Philippine Statistics Authority and ICF International 2014). In contrast, Figure 2 shows that more than 20% of non-users give reasons related to lack of access to a preferred method, and this is reinforced by evidence from the National Composite Index on Family Planning (NCIFP) survey on specific method access (Figure 11, below). In the context of the Philippine’s rapidly changing social norms, family planning supply has not kept up with demand.

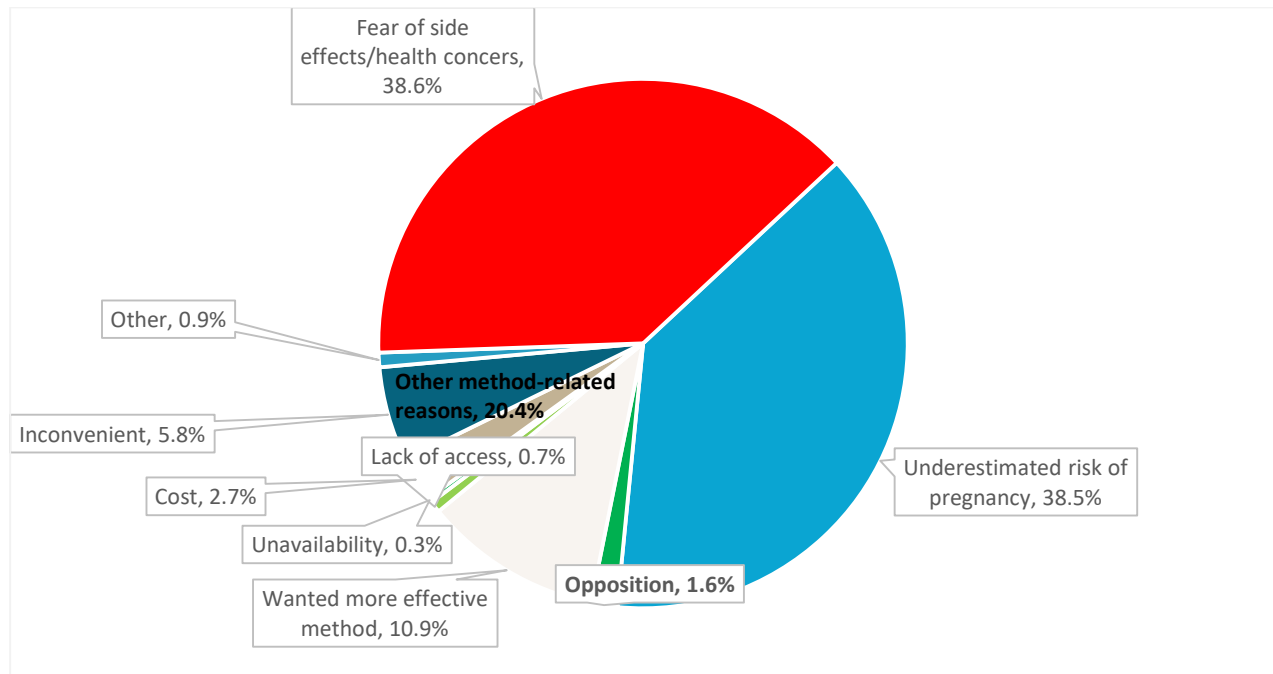


Figure 2. Common reasons for non-use or stopping family planning in the Philippines

Source: Special Tabulation of Philippines DHS 2013 data, presented in “Underlying causes of unmet need in Philippines,” Dr. Howard Sobel, WHO SEARO, 2018.

Expanding choice of modern methods, and specifically expanding access to the most effective methods, is a key intervention to increase mCPR (Ross and Stover 2013). An examination of the family planning choices of Filipino women highlights an unusual method mix, illustrated in Figure 3. Pills are the dominant method, with more than 50% of the market, and are primarily accessed through pharmacies. Longer-acting methods are surprisingly uncommon; among SP4PHC project countries, for example, injectables are the chosen method for more than 50% of Indonesian women, but only 13% of Filipinas. Contraceptive implants, which have been the target of negative publicity and a recent temporary restraining order in the Philippines, have a very small market share.

Private sector provision of family planning services, including counseling and provider-dependent methods, is limited. Those women who do choose injectables, intrauterine devices (IUDs), or implants receive them primarily through public hospitals; the private market for these contraceptive services is very small, as illustrated in Figure 4, below. This again is in stark contrast to regional peers, where private primary care providers (and midwives in particular) are a trusted source of confidential reproductive health services, and play a key role in providing family planning counselling and services. In Indonesia, for example, 52% of IUDs and 69% of injectables are supplied through the private sector (National Population and Family Planning Board et al. 2018).

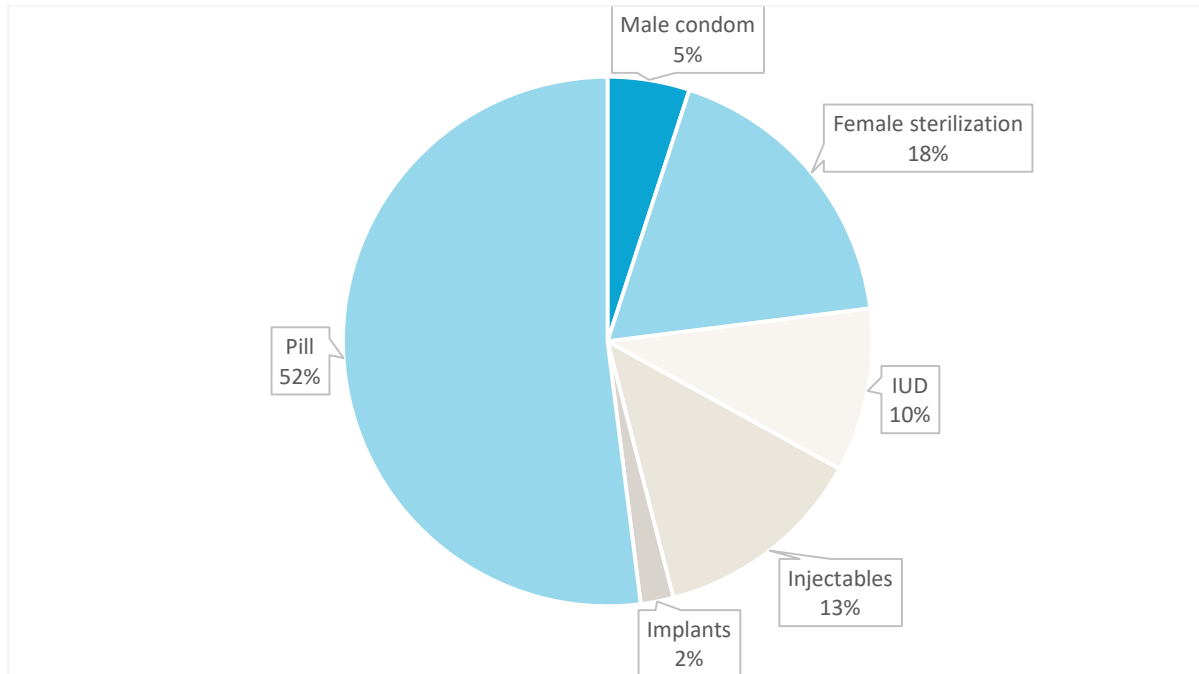


Figure 3. Modern contraceptive method use (married women), 2017

Source: Philippine Statistics Authority and ICF 2018

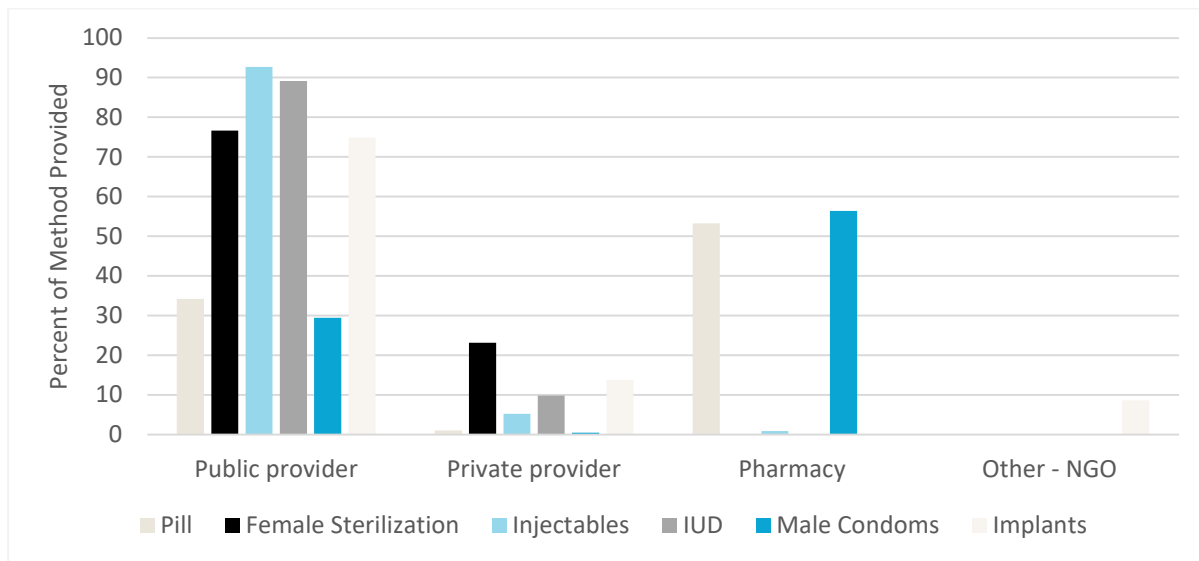


Figure 4. Sources of selected family planning methods, 2017

Source: Philippine Statistics Authority and ICF 2018

Private midwives in the Philippines do, in contrast, play a critical role in providing antenatal care (ANC) and birthing services; DHS data shows that 20-25% of both ANC and deliveries are in the private sector (see also analysis in Campbell et al. 2016). They serve the same women who seek family planning, and offer reproductive health services with similar social, technical and practical requirements. Globally, the private

sector plays an integral role in the delivery of family planning services (Campbell et al. 2016). Effectively engaging private providers increases the variety of service points available to women and contributes to sustainable markets for contraceptives (WHO 2017; Weinberger and Callahan 2017; Cahill et al. 2018).

An underperforming private sector in the Philippines therefore presents a key opportunity to increase access to high-quality family planning services. Demand outstrips supply of modern contraception, and while women visit private providers, and especially midwives, for other reproductive health services, they are not offered family planning options. For example, more than 3,000 private maternity facilities have registered with PhilHealth, but only around 10% of them are accredited for family planning services (discussed in more detail below, see Figure 19.)

Expanding access to family planning is an important goal of the Philippine government. Filipino women's rights activists and public health policymakers agree that expanding private sector supply of contraception offers an important opportunity to improve access and method choice (see, for example, DOH Initial Progress Report on Executive Order No. 12 - Zero Unmet Meet - Implementation). PhilHealth is the obvious mechanism through which this could be achieved; PhilHealth now covers almost all Filipinos and has established effective systems for contracting private health care providers. PhilHealth reimbursements could allow private facilities to provide free family planning services to those most in need and could stimulate the private sector to invest to fill critical service delivery gaps in underserved areas.

In an effort to encourage private (as well as public) providers to offer proactive counseling and a wider choice of the most effective family planning methods, in 2014 PhilHealth began to offer generous reimbursements to providers of LARCs. However, uptake of PhilHealth's offer has been disappointing; few providers have been accredited for the family planning service package, and although implant claim numbers are growing (as shown in Figure 22, below), the number of claims remains small. In 2018, PhilHealth received just over 20,000 claims for LARCs, in contrast with more than 7 million Filipino women with an unmet need for contraception.

Reasons for low uptake of PhilHealth's family planning reimbursements are unclear, and ThinkWell agreed to build on a longstanding relationship with PhilHealth to investigate. The specific objectives of this work were to:

- (1) Describe the current situation in terms of the overarching policy context and structure of health services, family planning trends, and the role of PhilHealth in the Philippines health sector.
- (2) Explain the process through which PhilHealth purchases family planning services, focusing on private midwives.
- (3) Explore reasons why so few midwives choose to contract with PhilHealth for family planning, and why so few claims are made.

From this analysis, this paper goes on to recommend options through which private midwives can effectively be engaged to increase access and choice in family planning in the Philippines.

II. METHODOLOGY

This mixed methods review began with a situation analysis that synthesized national survey data, DOH and PhilHealth reports and policy documents, and published and grey literature. The review included analysis of key legal frameworks, the Universal Health Care Law (Republic Act 11223), and the Responsible Parenthood and Reproductive Health Law (Republic Act 10354). The in-depth analysis of PhilHealth accreditation and claims processes was based on DOH, PhilHealth, and Professional Regulation Commission (PRC) issuances, reports, and manuals.

Secondary quantitative data from PhilHealth were obtained with permission from the PhilHealth Corporate Planning Department. Quantitative analysis of PhilHealth data on accreditation and claims reimbursement used Microsoft Excel.

Key informant interviews were conducted with key stakeholders. Interviews were conducted with representatives from the DOH (2), PhilHealth (3), the Integrated Midwives Association of the Philippines (IMAP) (1), and Private Practicing Midwives Association of the Philippines (PPMAP) (1).

These interviews supported the qualitative analysis of midwife perceptions, which was developed through five focus group discussions (FGDs). A total of 38 midwives and 5 private doctors providing maternity services took part in these discussions. Sampling was primarily by convenience; local midwives identified through IMAP were invited to take part in discussions. Two FGDs focused on providers based in urban settings (Quezon City, San Juan City), two more were with providers practicing in a rural / suburban context (Leyte and Bulacan provinces), and a final discussion was with mixed rural and urban providers. As this is a scoping review and not a formal research endeavor, written informed consent was not secured from the respondents. Nonetheless, verbal assent to participate (and be quoted) was obtained from the respondents. Anonymity and confidentiality of information were provided upon request. All interviews were audio recorded and transcribed, with the key points summarized in English. Manual thematic analysis was applied to the qualitative data.

III. SITUATION ANALYSIS

Policy Context

Health is a basic human right guaranteed by the Philippine Constitution of 1987. Philippines public sector health services are delivered by government facilities under the national and local governments and are financed through a mix of tax-based budgeting system and through a social health insurance mechanism (PhilHealth). The DOH supervises the government corporate hospitals, as well as specialty and regional hospitals. At the local level, provincial governments manage and operate district and provincial hospitals, while municipal governments provide primary care, including preventive and promotive health services and other public health programs through the rural health units, health centers, and *barangay* (village or ward) health stations. The private sector is largely market oriented, where health care is generally paid for through user fees at the point of service. The private sector's share of total hospital beds increased from 46% in 2003 to 53% in 2016 (WHO Regional Office for South-East Asia 2018).

Philippine laws provide a strong foundation for increasing access to family planning services and removing financial barriers for those seeking them. The Responsible Parenthood and Reproductive Health Act (Republic Act No. 10354), enacted in 2012, recognizes access to reproductive health care as a basic human right (Committee on Population and Family Relations 2011). It ensures universal access to family planning, sexual education, and maternal health care. Given the prevalence of conservative religious beliefs in the Philippines,

the law was highly controversial; in 2013 the Supreme Court halted implementation of the law, and in 2015 it issued a temporary restraining order that halted distribution of hormonal contraceptives to public health facilities. President Duterte lifted the restraining order in 2017 in order to support full implementation of the Responsible Parenthood and Reproductive Health RPRH Law (UNFPA 2017) and emphasized his commitment to family planning access by issuing Executive Order (EO) No. 12, “Attaining and Sustaining Zero Unmet Need for Modern Family Planning” on January 9, 2017.

The Universal Health Care Law (Republic Act No. 11223), passed in 2019, is intended to ensure that every Filipino can access the full continuum of health services without resulting financial hardship. It specifies that PhilHealth, the government’s national health insurance agency, shall become a key national purchaser of health services, with primary responsibility for ensuring that all Filipinos are protected from financial risk when accessing essential health services. The UHC Law automatically enrolls all Filipinos in PhilHealth’s National Health Insurance Program (established under the National Health Insurance Act of 1995, amended in 2013; more detail in the PhilHealth section, below). Additionally, the UHC Law prescribes a wide range of health systems reforms related to governance, regulations, human resources, service delivery, and financial management (Obermann, Jowett and Kwon 2018) and illustrated in the DOH graphic (Figure 5).

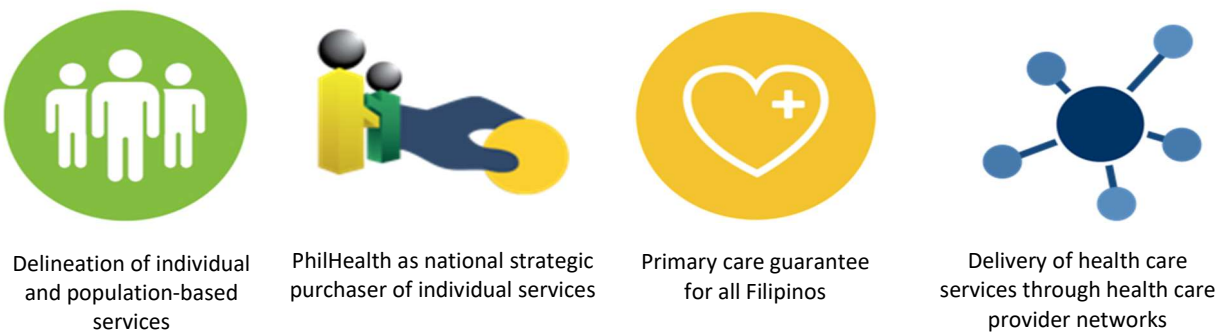


Figure 5. UHC Law graphic summary, DOH 2018

Family planning’s place in the UHC reforms is the subject of active debate, and is currently unresolved.

Government health financing in the Philippines will be divided between “individual-based services” and “population-based services.” “Individual-based services”—health care services whose benefits can be traced to one individual—will be financed by PhilHealth. “Population-based services”—health care services that act at a population level, including, for example, health promotion and surveillance—will be financed by the local government unit (LGU) and/or by DOH. Family planning can be traced to an individual, but it has been argued that because of externalities that benefit the population as a whole, it should remain the responsibility of DOH. Currently, responsibility for financing family planning remains unclear and is the subject of active discussion.

This classification of family planning under the UHC Law has significant implications for the ability of government to engage private providers to expand access to family planning. Should all family planning services be considered “population-based services,” financing will sit with DOH and LGUs. These agencies have limited capacity to contract with private providers, little relevant experience, and uncertain motivation. It is unlikely that they would effectively engage private providers in family planning service delivery. Alternatively, positioning all family planning finance within PhilHealth (by classifying family planning as an individual-based

service) could undermine the DOH’s ability to deliver the essential functions of a family planning program, including, for example, social behavior change communications, provider training, and quality assurance. Responsibility for procurement and distribution of contraceptives, long an issue of debate in the Philippines, could be further complicated. Further implications are discussed in the Recommendations section below.

The UHC Law describes health care provider networks (HCPNs) that PhilHealth will contract to provide individual-based services and by the DOH or LGUs to provide population-based services. Private providers may be expected to engage in mixed provider networks or potentially in exclusively private networks. Potential benefits for small private providers could include improved access to commodities (including contraceptives) and reduced pricing through consolidated procurement. The administrative burden of PhilHealth engagement may also be reduced through participation in a network by, for example, facilitating claims processing. However, contractual relationships within networks may take time to sort out, and some providers may prefer to maintain direct contact with PhilHealth; it is expected that this option will be maintained for the time being. Further implications for small private providers, and indeed their willingness to participate in these networks, remain unclear.

The UHC Law reforms may have implications for the structure of commodities financing in the Philippines. It has been suggested that prospective PhilHealth payment be used by contracted networks and facilities to purchase commodities associated with individual-based health services, but mechanisms for this new provider payment scheme and spending guidelines are still under discussion. One option includes adding commodity cost to PhilHealth payment rates and expecting providers (or service delivery networks) to purchase what they need, preferably through the DOH at centrally negotiated rates, or potentially enabling providers to procure directly from the private market.

In addition to these landmark reforms, the Philippine Development Plan 2017-2022 highlights access to family planning as critical to achieving economic growth and the Sustainable Development Goals. The Philippines has also made commitments through FP2020 to increase access to family planning including through more effective engagement with the private sector. These initiatives highlight the momentum in the Philippines to increase access to family planning.

Family Planning

Despite government commitment, family planning outcomes in the Philippines show inequities and lag behind other countries in Southeast Asia. Figure 6 shows that mCPR and the percentage of demand satisfied by modern methods in the Philippines are low compared to other countries in the region, while unmet need for family planning is relatively high.

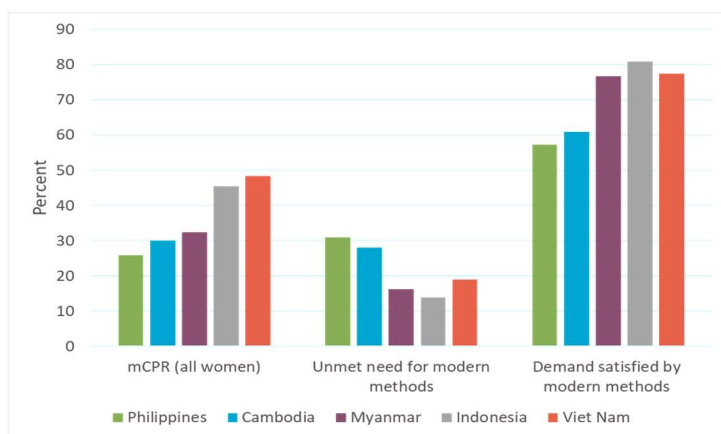


Figure 6. Family planning outcomes in Southeast Asia

Source: Track20 website, <http://www.track20.org/StatTrack/> accessed June 2019. Data for all women, modern methods.

Only 25% of all women and 40% of married women in the Philippines use a modern method of contraception. By comparison, mCPR among married women is approximately 51% in Myanmar, 62% in Indonesia, and 80% in Thailand (DHS Program 2019; WHO Regional Office for South-East Asia 2016). While 17% of all married women have an unmet need for family planning, this increases to 28% of married adolescents. Unmet need among sexually active unmarried women is 49%, though this increases among poor and rural women. Of those with an unmet need are 66% of rural women and 62% of women in the lowest economic quintile.

Family planning need is reflected in fertility rates in the Philippines. A comparison of wanted and actual

fertility by wealth quintile, analyzed from 2017 DHS data, suggests that the gap between actual and desired number of children is largest among the poorest sections of the population (see Figure 7). The total fertility rate (TFR) has declined from 4.1 children per woman in 1993 to 2.7 in 2017. However, the “wanted fertility rate” is 2.0, meaning that, on average women have 0.7 more children than they want. Similarly, household wealth is a determinant of birth interval; women in the poorest households have the shortest median birth intervals, 31.2 months, compared to 52.6 months among women in the wealthiest households.

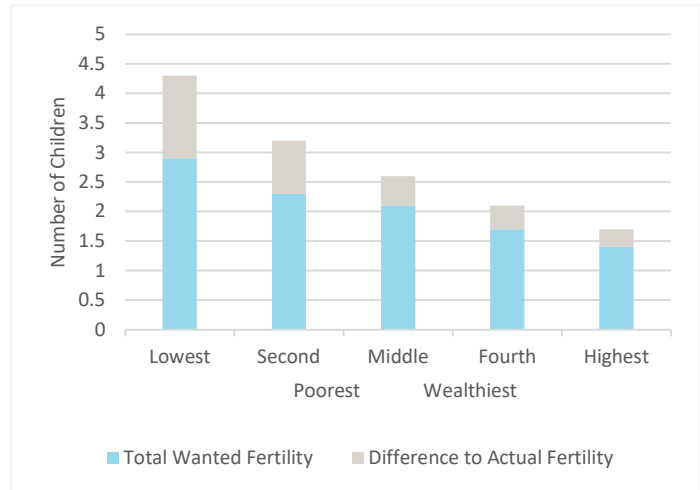


Figure 7. Modern contraceptive method use (married women, by wealth quintile), 2017

Source: Philippine Statistics Authority and ICF 2018

Fertility intentions do not limit growth in the use of family planning in the Philippines.

FP2020 has modeled the relationship between ideal number of children and mCPR to create a “demand curve.” Countries and regions may be mapped to illustrate the potential for growth in contraceptive use without changes in underlying demand (see Figure 8, below). The Philippines is among countries where there is a high “potential use gap” between demand and supply, and in which it is more likely to see substantial increases in mCPR from investments to improve and expand family planning service delivery, as compared to investments in social behavior change.

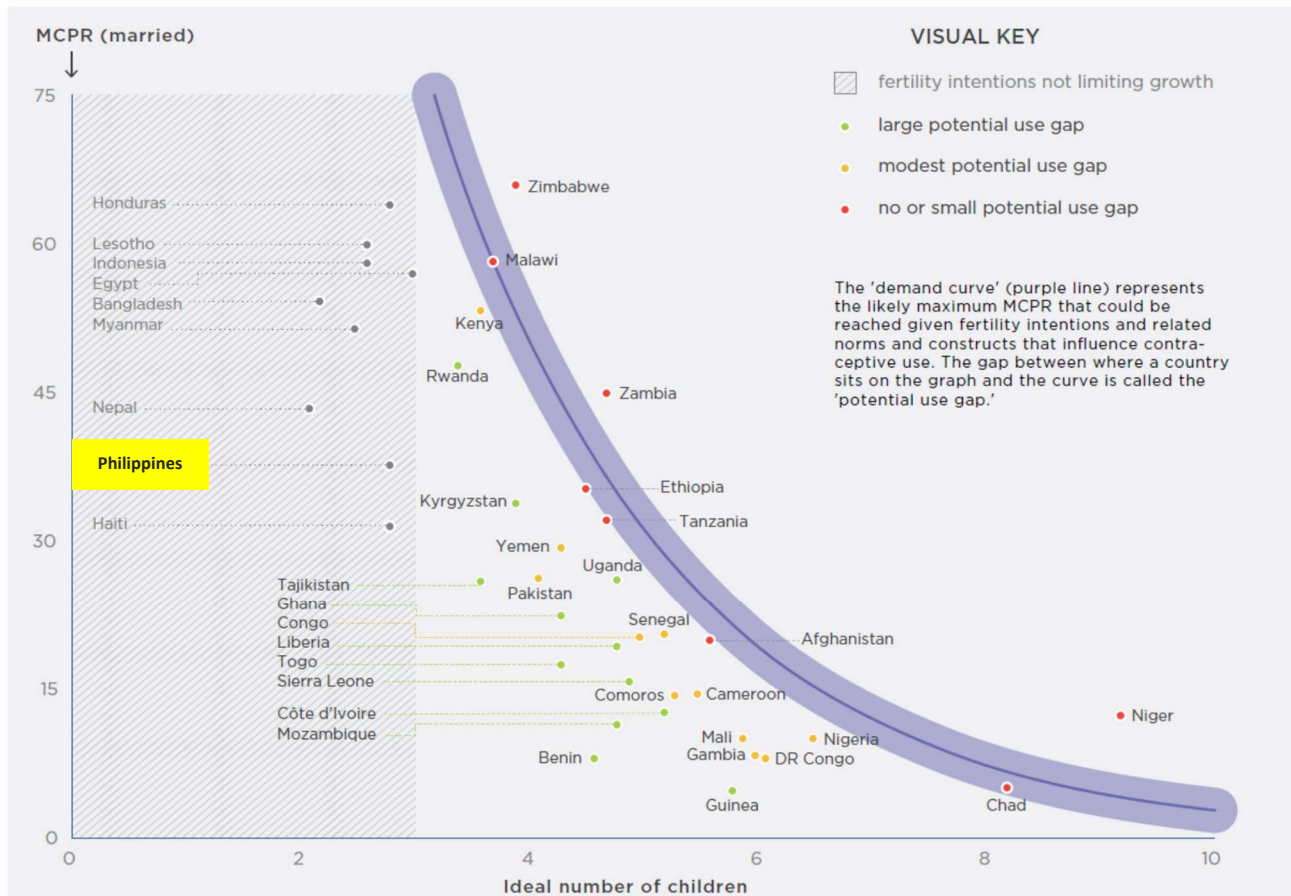


Figure 8. FP2020 demand curve

Source: FP2020 Annual Report 2016 – 2017, "The Way Ahead"

The Philippines has seen significant increases in the use of modern family planning over the last 20 years, but from a very low base. Figure 9 illustrates these trends, using DHS data, with unmet need dropping below 20% but flattening out between 2013 and 2017.

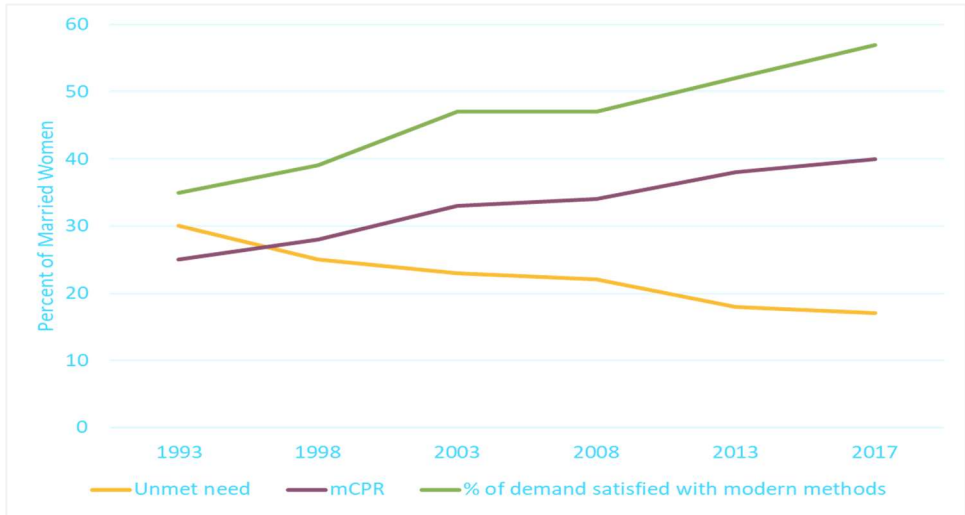


Figure 9. Trends in modern contraceptive use among married women in the Philippines, 1993-2017

Source: Philippines National Demographic and Health Surveys

The contraceptive method mix in the Philippines is biased toward short-term methods, which may reflect limited access to LARCs. Figure 10 illustrates method mix, including traditional methods and comparing married and unmarried women. A skewed method mix may reflect lack of access to the full range of methods. A balanced method mix empowers individuals to choose the method that facilitates their reproductive goals, whether that means to limit, space, or delay births. Countries with a consistently high availability of a range of methods also tend to have higher mCPR (Ross et al. 2001).

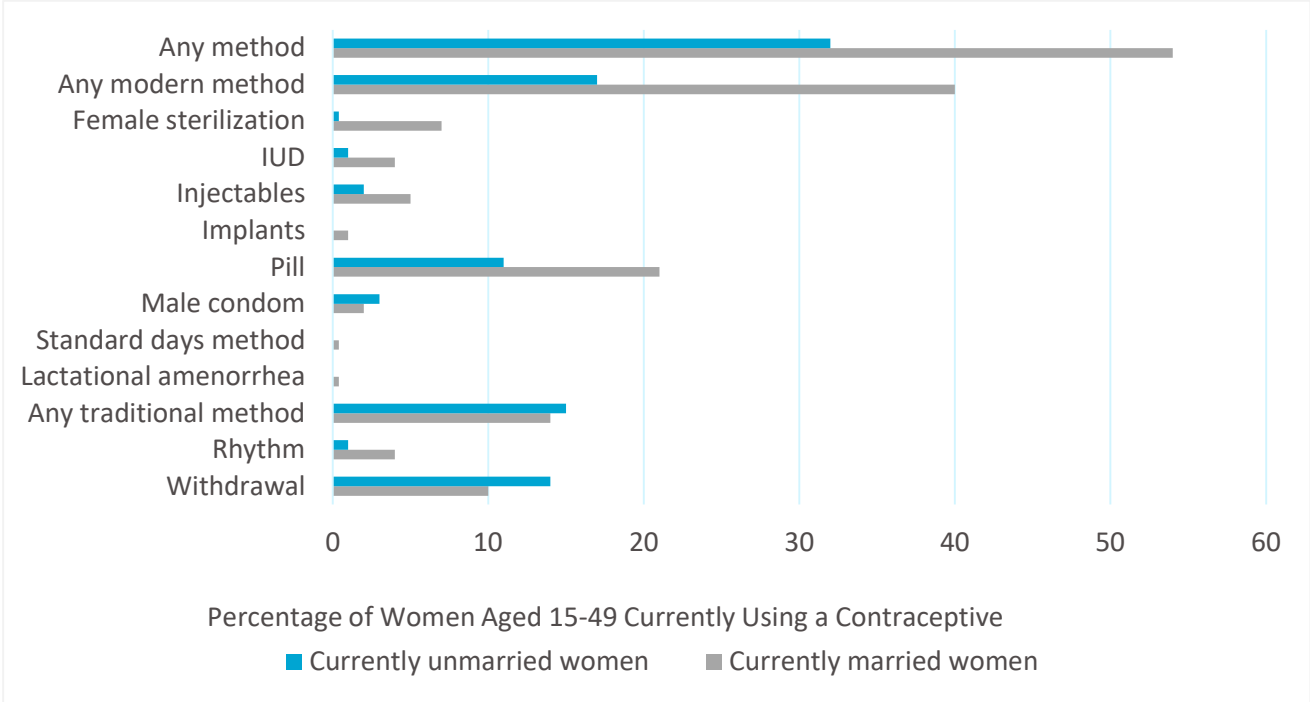


Figure 10. Contraceptive Method Use (married and unmarried women), 2017

Source: Philippine Statistics Authority and ICF 2018

Access to family planning in general, and LARCs in particular, is limited in the Philippines. Figure 11 below summarizes data from FP2020’s National Composite Index on Family Planning (NCIFP) survey in 2014, demonstrating that more than half of women in the Philippines do not have access to implants, injectables, or IUDs.

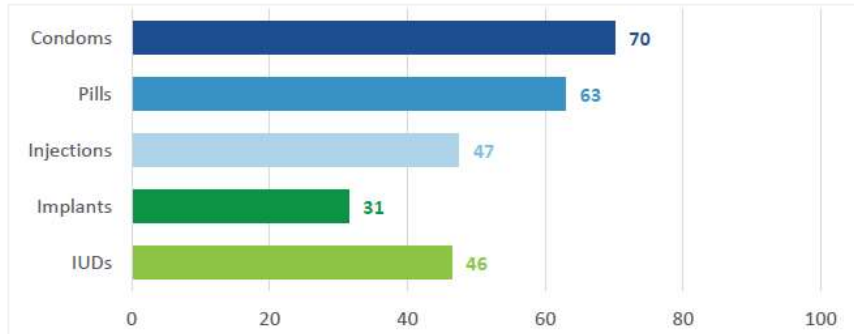


Figure 11. Proportion of the Philippine population able to access family planning methods

Source: FP2020—Exploring Opportunities for mCPR Growth in the Philippines, data from NCIFP 2014

LARCs are the most effective reversible methods and have the benefit of being convenient, cost-effective over time, and generally acceptable to users (Stoddard, McNicholas, and Peipert 2011; Steiner et al. 2006; Halpern et al. 2013; Lipetz, Phillips, and Fleming 2009). However, these methods require higher initial financial output than short-term methods, which may pose a financial barrier to women. Short-term methods are associated with higher discontinuation rates than LARCs and are more expensive over time (Bradley, Schwandt, and Khan 2009). In the Philippines, the oral contraceptive pill is the most commonly used modern method among currently married women, followed by female sterilization. Few women in the Philippines use LARCs. As of 2017, only 4% of married women had an IUD, while 1% had a subdermal implant (SDI). The percentages are even lower among unmarried sexually active women. At approximately 14%, traditional method use remains common among married and unmarried women.

The supply of family planning options that require service from a trained provider is concentrated in the public sector (Figure 12), where these services are available free of charge. In contrast, the majority of couples choose family planning methods that do not require a trained provider, such as pills (52%) and condoms (5%), and most access these products from private pharmacies. Free family planning services are available in the public sector at hospitals and in primary health care facilities, including health centers and *barangay* health stations, and from *barangay* health workers. Within the private sector, clients generally pay for family planning services from hospitals and primary health care clinics, including birthing homes, lying-in clinics, and (potentially) newly introduced free-standing family planning clinics. The vast majority, 80-90%, of birthing homes are privately owned by midwives (Gomez 2019). All family planning methods may be delivered at the primary care level, except for female sterilization, which must be conducted at a hospital. Public facilities receive free commodities from the national family planning program, while private facilities generally do not. Recent DHS data shows that only 7% of all contraceptive users attain their method in a private hospital or clinic; this includes the 23% of female sterilizations provided at private hospitals. Only 9% of IUDs and 14% of SDIs are provided in private facilities. The small share of LARCs provided in private sector facilities suggests an opportunity for private primary care providers to assume an increased role in the provision of family planning services.

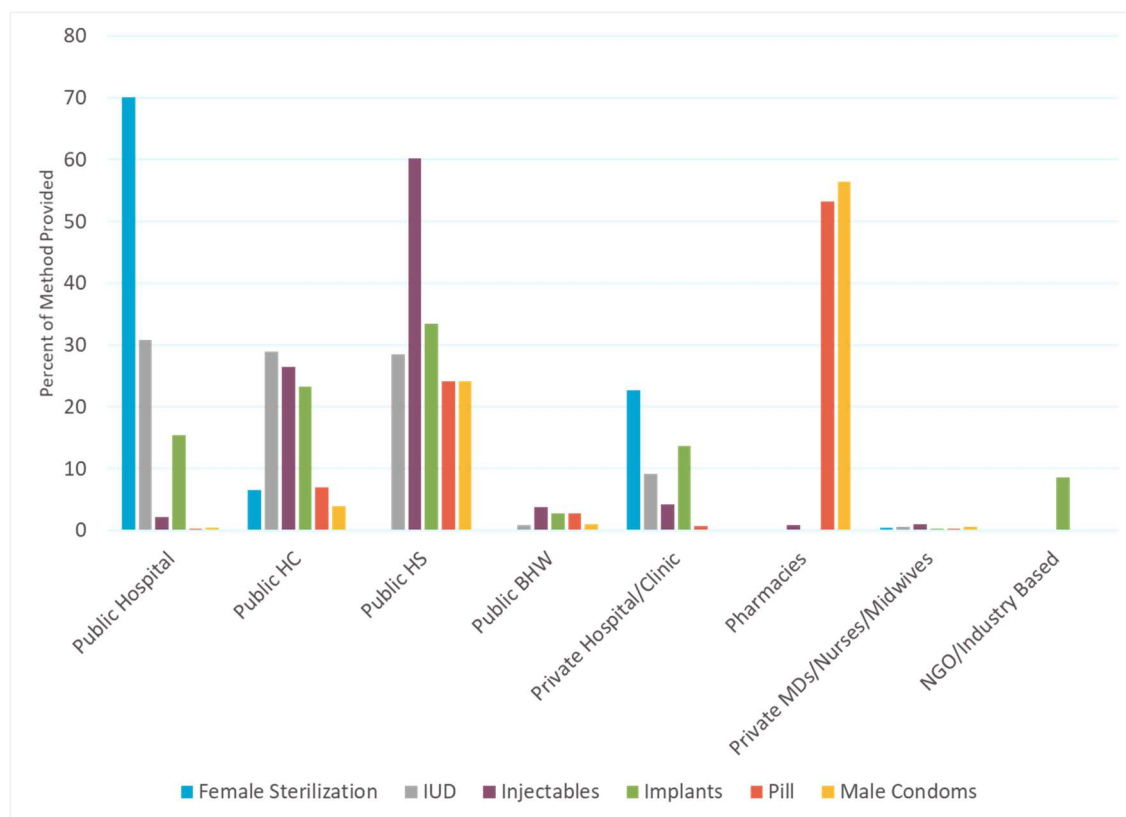


Figure 12. Source of modern contraceptive methods, 2017

Source: Philippine Statistics Authority and ICF 2018

Few providers proactively seek opportunities to offer counseling on family planning. Research conducted recently in the Philippines by the World Health Organization (WHO) reveals that more than 80% of women seeking reproductive or child-related health care in public facilities do not receive counseling on family planning and, among those who do, the quality of the counseling is low (Sobel 2018).

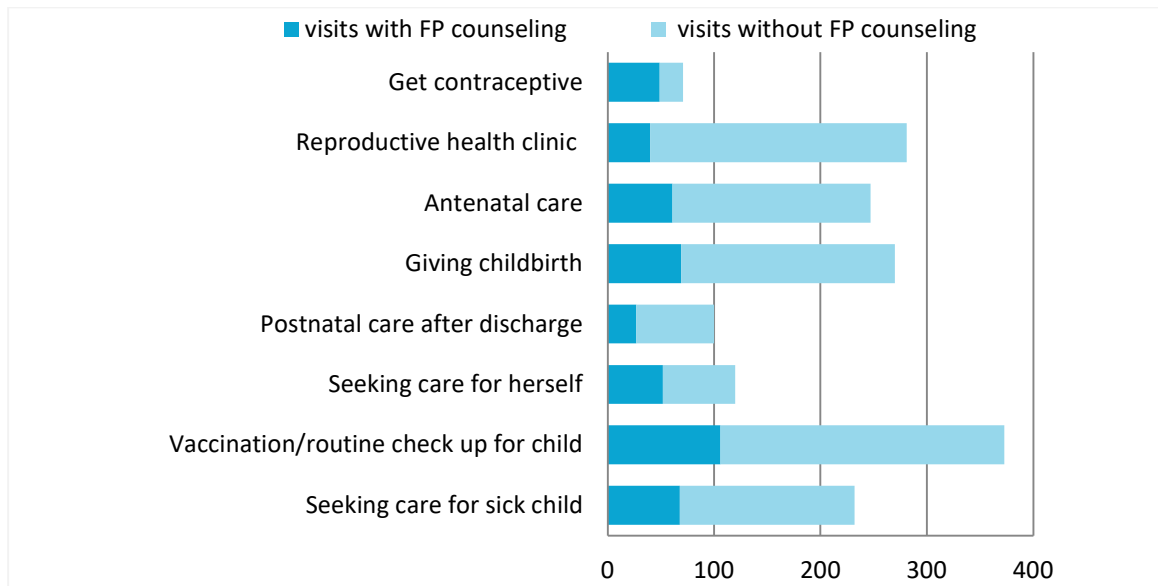


Figure 13. Missed opportunities for family planning in the Philippines, 2018

Source: Sobel 2018

The low proportion of women receiving FP counseling, even when visiting a provider for a reason directly related to reproductive health, suggests that providers rarely seek opportunities to offer FP counseling, but rather wait to be asked. Remarkably, one-third of women who sought care at a public facility specifically to get contraception left the facility without receiving any family planning counseling or contraception (Sobel 2018, illustrated in Figure 13). Social norms about family planning may limit the willingness of providers as well as clients to initiate these discussions. It is therefore reasonable to suggest that overcoming these barriers may require stronger incentives than might be expected in different circumstances.

“Of course, in paper, it would be nice if we can do comprehensive counseling before. And with both [the husband and wife] present, ideally. In practice, though, you just plug it [the IUD] in, chat a bit, and they go.”

The Philippines has a strong private health sector that can be leveraged to increase access to family planning and thus increase mCPR. The Philippines has a vibrant private health sector, commonly used by women of reproductive age, but these private providers rarely offer family planning services. Of all the hospitals accredited by PhilHealth, 65% are private (PhilHealth 2018). Although the total number of privately owned primary care facilities is not known, the number of privately owned birthing homes and lying-in clinics accredited by PhilHealth has increased markedly in the past decade (Yason-Remonte 2018). Private sector providers conduct 23% of all births and 23% of all female sterilizations (Philippine Statistics Authority and ICF 2018). Over half of those using pills and condoms purchase them from private pharmacies. Women also regularly take their children to private facilities for treatment; for example, 36% report taking their children to a private provider for care related to a fever. Yet, private primary health facilities provide less than 7% of family planning services (Philippine Statistics Authority and ICF 2018). This indicates an opportunity for private sector primary care providers to expand provision of family planning services, filling a gap in the Philippine

market, especially for LARCs and injectables, which are underused in the Philippines and require a trained professional to provide. In many circumstances, women may prefer to access services in the private sector rather than in the public sector due to convenience or perceived quality of services. Leveraging the private sector to increase access to family planning services while protecting women from financial hardship has the potential to increase mCPR in the Philippines.

PhilHealth: The Philippine National Health Insurance Corporation

PhilHealth is the government-owned and -managed corporation that runs the National Health Insurance Program, the objective of which is to achieve UHC for the population. The biggest insurance risk pool in the Philippines, PhilHealth determines membership in the scheme, collects premiums, accredits providers, establishes the benefit package and provider payment mechanisms, processes claims, and pays providers for services delivered. Figure 14 shows that government accounts for approximately 32% of total health expenditure. Of this, PhilHealth constitutes the largest share, increasing from 7% of health spending in 2000 to 14% in 2014. However, at 56%, the bulk of health spending in the Philippines comes from out-of-pocket expenditures (Dayrit et al. 2018).

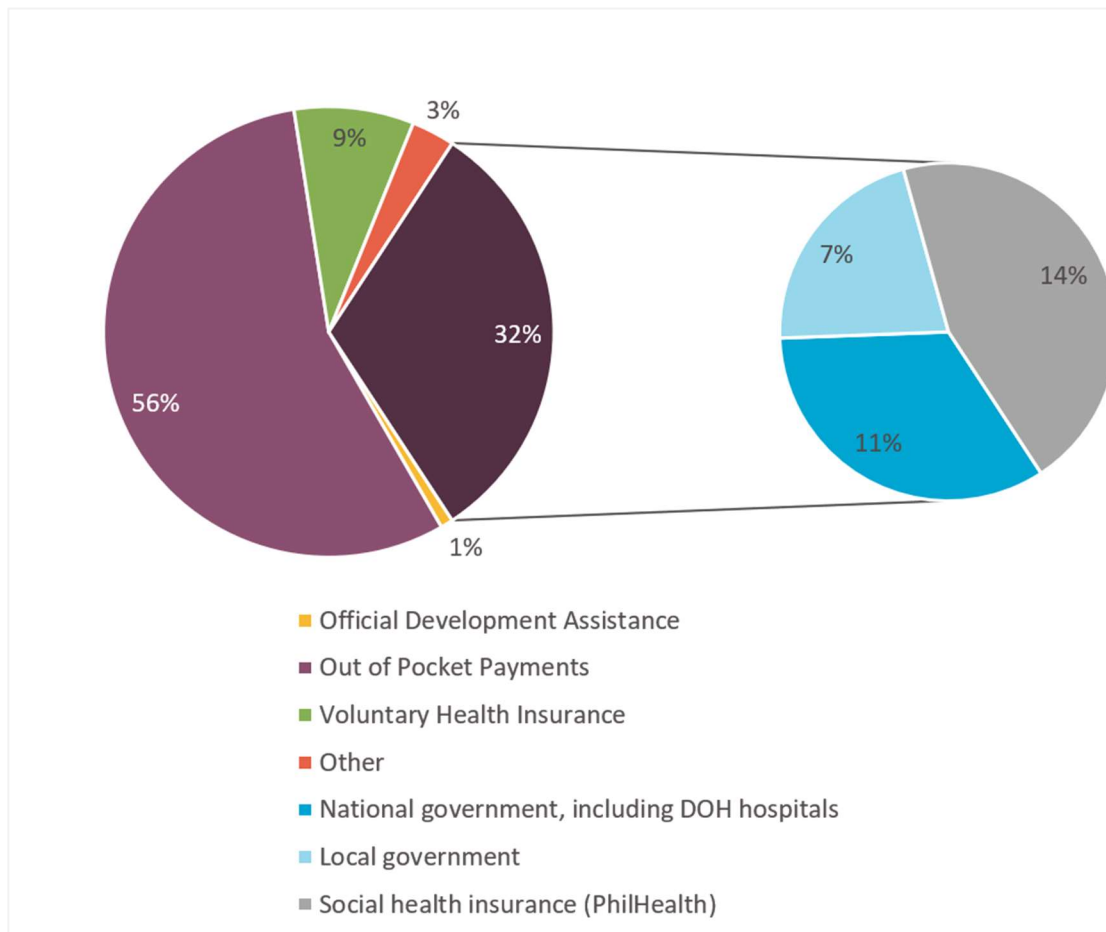


Figure 14. Share of total health expenditure by source of revenue

Source: Dayrit et al. 2018. The Philippines Health Systems Review. Vol. 8. 2 vols. New Delhi: World Health Organization, Regional Office for South-East Asia.

PhilHealth currently covers approximately 92% of the population, up dramatically from 75% in 2012 (Dayrit et al. 2018). Membership in PhilHealth has long been compulsory, but the 2019 UHC Law ensures automatic membership in PhilHealth for all Filipino citizens. As of 2017, coverage included approximately 97 million people, which includes enrollment of members plus coverage of their families as beneficiaries. It should be noted, however, that not all of these members are aware of their rights and benefits; only 66% of the population self-reported having coverage from PhilHealth in the 2017 DHS. Although coverage is expanding, PhilHealth reports relatively low benefits utilization; only 12% of all members utilized their benefits in 2017. Low benefits utilization is likely due to maldistribution of health facilities and lack of knowledge about membership status and benefits (Dayrit et al. 2018). The scheme has eight membership categories: public or private sector employees, overseas Filipino workers, informal sector employees, indigents, sponsored members, lifetime members, and senior citizens. Sponsored members are those whose premiums are paid by other individuals or institutions. Indigents are not required to make formal contributions; since the National Health Insurance Act was amended in 2013 (Republic Act 10606, amending Republic Act No. 7875, otherwise known as the National Health Insurance Act of 1995), health care for poor households identified by the National Household Targeting System for Poverty Reduction has been fully subsidized by the national government through revenues from tobacco and alcohol taxes (Republic Act No. 10351, also known as the Sin Tax Reform Law). Lifetime members have reached retirement age and have paid at least 120 monthly premium contributions. Figure 15 shows the proportion of PhilHealth members by group (PhilHealth 2018). One objective of the UHC Law is to simplify PhilHealth membership categories down to just two: directly contributing and indirectly contributing members.

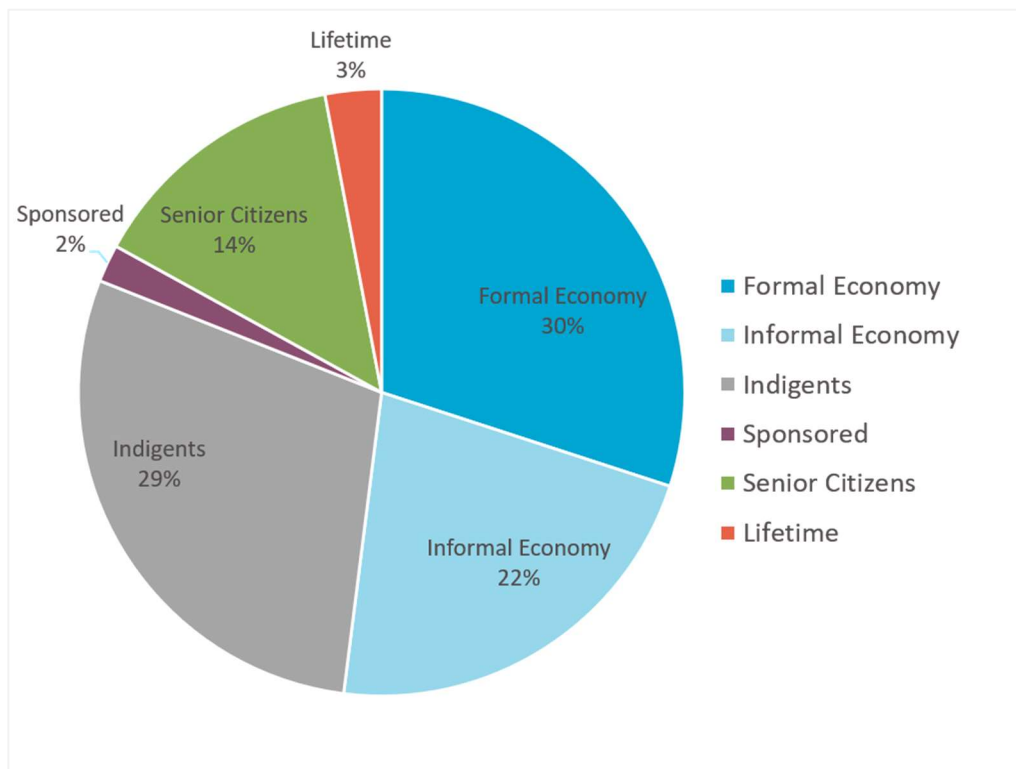


Figure 15. Proportion of PhilHealth members, by group

Source: PhilHealth Statistics and Charts 2017

PhilHealth benefits primarily cover hospital-level services, although benefits have grown to include more primary care services, including an expanded family planning package, in recent years. Hospital-level services include in-patient care, deliveries, and outpatient treatments. Inpatient care includes room and board, medicines, diagnostics, professional fees, and operating room services. The family planning package covers long-acting and reversible contraceptives (IUDs and SDIs) as well as permanent methods (tubal ligation and vasectomy). While PhilHealth ultimately aims to provide consistent benefits across membership categories, current operational and financial constraints mean that sponsored members and indigents receive more benefit coverage than other groups (Dayrit et al. 2018). Sponsored members and indigents are eligible for no-balance billing at public hospitals as well as the primary care benefit package (PCB1) at RHUs. The employed sector is currently covered by the expanded primary care benefit (ePCB) that can be accessed in government hospitals and private clinics. Additionally, there are select case rates for services at primary care, including maternity care, tuberculosis DOTS, animal bite, and family planning. In light of the UHC Act, PhilHealth plans to improve its primary care benefit.

PhilHealth purchases services from both public and private health care providers. Of private hospitals, 79% are accredited, compared with 68% for government hospitals (WHO Regional Office for South-East Asia 2018). However, these rates vary significantly between regions, with rates well under 50% in the poorest regions (WHO Regional Office for South-East Asia 2018); this means that the people in these regions find it much harder to access high-quality care and be reimbursed by PhilHealth compared to those in richer regions. The process of accreditation is complex, and is detailed below.

PhilHealth estimates the cost of services and pays providers through several different mechanisms, including capitation and case-based payments. For inpatient services, PhilHealth has moved away from fee-for-service payment with benefit ceilings to case-based payment. Reimbursements made to public hospitals, as well as to all private facilities, go directly to the facility, while reimbursements for public primary facilities go to the LGU to use at their discretion. In effect, these public primary care facilities receive input-based financing, which may dilute the potential influence that PhilHealth payments have on provider behavior (Cico 2018). The UHC Law requires government units managing HCPNs to establish a special health fund to ring-fence funds for health services. Payment to private hospitals and primary care facilities currently goes directly to the facility. Mechanisms through which private facilities may be able to join public HCPNs or form their own networks are under discussion as DOH and PhilHealth policies develop related to UHC Law and could impact payment mechanisms.

PhilHealth payment rates rarely cover the full cost of services. PhilHealth uses “support value”—the percentage covered by PhilHealth of the total cost incurred during a hospital stay—to measure financial protection. PhilHealth reported a 55% support value in 2017 (PhilHealth 2018) but recognizes wide regional variation. The Philippines Health System Review 2018 summarizes various sources to estimate that “PhilHealth can reimburse only 30–60% of hospitalization costs, leaving 40–70% for patients to bear.” In response to this, PhilHealth’s “no-balance billing” policy was recently extended (PhilHealth Circular 2017-006) to explicitly forbid government-owned hospitals from charging patients (indigent, sponsored, senior, lifetime members) anything over and above what PhilHealth reimburses for case rates, Z-benefits,¹ and primary benefits, but still leaves room for copayments to persist for other patient groups and services. In addition, the circular extends no-balance billing to apply to private sector family planning providers for the same set of eligible patients, potentially removing financial barriers for those most in need but also limiting the opportunity for private providers to cover costs by charging copayments from these groups.

¹ Z-Benefits were introduced in June 2012 in response to calls for a “catastrophic fund” and with the aim of covering particularly costly procedures and provide financial risk protection.

PhilHealth faces many challenges, but the 2019 UHC Law designates PhilHealth as the national purchaser of health services, and the significance of PhilHealth’s role in the Philippines health sector will continue to grow as PhilHealth prepares to implement key provisions of the UHC Law in relation to provider payments and benefit package expansion.

IV. PHILHEALTH PURCHASING OF FAMILY PLANNING

This section describes the mechanisms through which PhilHealth purchases family planning services, focusing on private providers, especially midwives. Accreditation—the term used to describe the process of establishing a contract between PhilHealth and a provider—is the first topic, and then the process of claims submission and reimbursement. Finally, data from PhilHealth are reviewed to assess the current performance of these approaches.

Accreditation Processes

Facilities must be accredited by PhilHealth prior to receiving reimbursement for services. Private sector midwives may own and operate two different kinds of facilities: birthing homes and free-standing family planning clinics. Birthing homes are inpatient facilities equipped for normal deliveries. Free-standing family planning clinics were introduced in 2017 and are outpatient facilities that provide all modern methods of family planning except female sterilization (bilateral tubal ligation or BTL). (At the time of writing, few if any facilities have been accredited for free-standing family planning.) These facility types have different DOH licensing and certification requirements. Birthing homes require a full licensing process, while free-standing family planning clinics undergo a much simpler certification process. Figure 16 illustrates the PhilHealth Facility Accreditation process for both birthing homes and free-standing family planning clinics.

The accreditation process for birthing homes and free-standing family planning clinics includes several steps and starts with professional licensing and accreditation. Although PhilHealth reimbursements are paid to facilities rather than to individual providers, the first requirement that a private sector midwife must satisfy in order to work at or own a facility eligible for PhilHealth reimbursement is to attain a professional regulation commission (PRC) license (Figure 16, 1). In order to attain the PRC license, a graduate with a bachelor’s degree in midwifery must pass the professional licensure exam. The license may be renewed every three years if the midwife has completed 45 units of continuing professional development activities over the course of this time. After the midwife has attained her PRC license, she may apply for PhilHealth Professional Accreditation (Figure 16, 2), which is conditional upon completing additional specialized training on LARC provision from trainers designated by PhilHealth. It also depends upon securing a Memorandum of Agreement (MOA) to refer complicated pregnancies to either an accredited partner physician, interlocal health zone, or a basic emergency obstetric and newborn care (BEmONC) or comprehensive emergency obstetric and newborn care (CEmONC) network. After the midwife has attained the PRC license and the PhilHealth Professional Accreditation, she is eligible to work at an accredited birthing home or free-standing family planning clinic.

Midwives aiming to receive PhilHealth reimbursements for a birthing home that they own must first attain a Department of Health License to Operate (DOH-LTO), which entails meeting numerous requirements. First, the owner must register the birthing home with the Department of Trade and Industry and the Securities and Exchange Commission. Once registration is complete, facilities must secure various business permits intended to ensure that the business is safe for operation and pays taxes. Once all the required business permits are secured, the birthing home may apply for the DOH Permit to Construct (PTC), which ensures compliance with the architectural specifications of the DOH. The birthing home must also demonstrate that it complies with necessary staffing, equipment, and protocol requirements. Once the facility owner can demonstrate

satisfaction of these requirements, an application may be completed. A DOH inspector then evaluates the facility and, if the facility is compliant, recommends the issuance of the DOH-LTO (Figure 16, 3).

After receiving the DOH-LTO, the owner of a birthing home may apply for PhilHealth accreditation (Figure 16, 4) to provide and claim for the maternal care package (MCP), and may also claim for family planning services once they demonstrate that they have up-to-date DOH-approved training. The MCP includes antenatal care, delivery, postpartum care for the mother, and newborn care. Once the birthing home receives PhilHealth MCP accreditation, it is eligible to receive reimbursement for these services. PhilHealth facility accreditation must be renewed annually, which entails an annual onsite inspection. Importantly, birthing homes that receive PhilHealth accreditation may provide family planning services and receive reimbursement without applying for additional certification as long as the facility submits DOH-approved family planning training certifications for its providers.

The certification of free-standing family planning clinics commenced in 2018 and was a measure proposed by midwife associations in the Philippines to increase access to family planning services by addressing the difficulty of attaining the DOH-LTO. Midwife associations successfully argued that high-quality family planning services could be provided without meeting all the standards required for the DOH-LTO and that a simplified certification process would be sufficient. Thus, the DOH certification process for free-standing family planning clinics follows the same process as the DOH-LTO process but does not include adherence to the same architectural standards required of birthing homes. The main additional requirement is that facility personnel complete DOH-approved IUD and SDI insertion training. The Certificate of Compliance with Free-Standing Family Planning Clinic Standards remains valid for three years and must be renewed annually. Once it has been issued, the owner may apply for PhilHealth facility accreditation and subsequently receive reimbursement. At the end of 2018, PhilHealth had not accredited any free-standing family planning clinics.

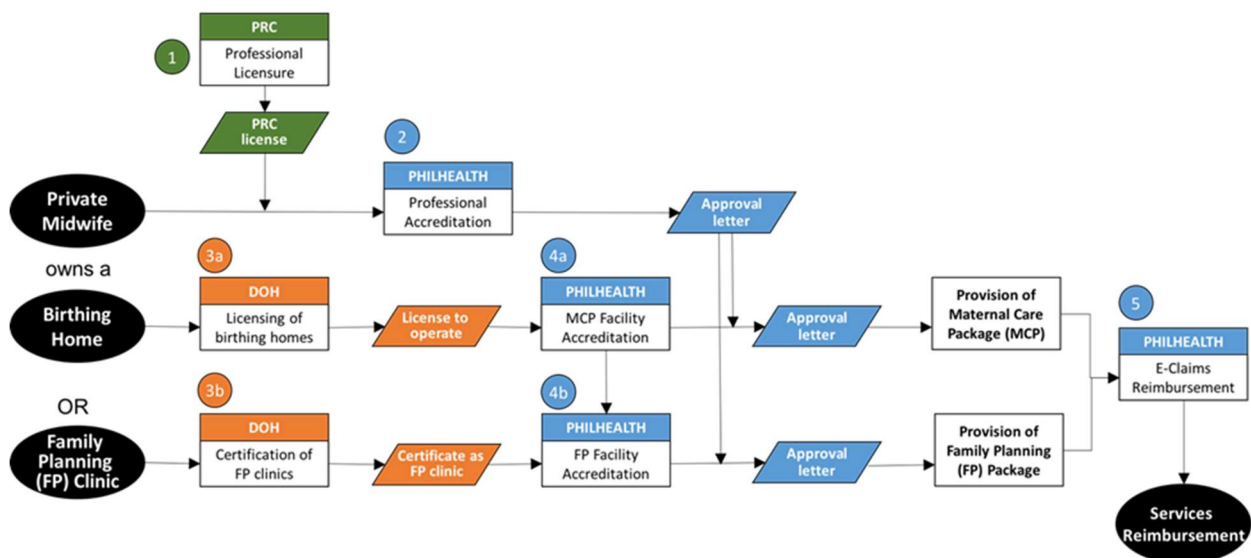


Figure 16. Overview of Department of Health and PhilHealth accreditation and licensing processes

Source: Graphic developed by ThinkWell Philippines, 2018

Claims Reimbursement Process

Beginning in January 2018, PhilHealth started requiring the use of eClaims for all accredited facilities. Figure 17 illustrates the PhilHealth claims reimbursement process. To file eClaims, a facility must use PhilHealth-certified eClaims software and an auto credit payment scheme bank. Facilities may develop their own

PhilHealth certified eClaims processing software or hire an intermediary health information technology provider (HITP) to provide it. Once a claim is entered into the system, it is transferred to both the regional and central PhilHealth offices. Claims processing is completed at the regional level; however, the eClaims server is lodged at the central office. In addition to sending the eClaims, midwives must manually complete, copy, and send hard copies to the regional PhilHealth office, where it is reviewed and cross-verified against the electronic records sent to the regional office. Complete claims are validated while incomplete or deficient claims are returned to the facility or denied. PhilHealth aims for a turnaround time of 30 days.

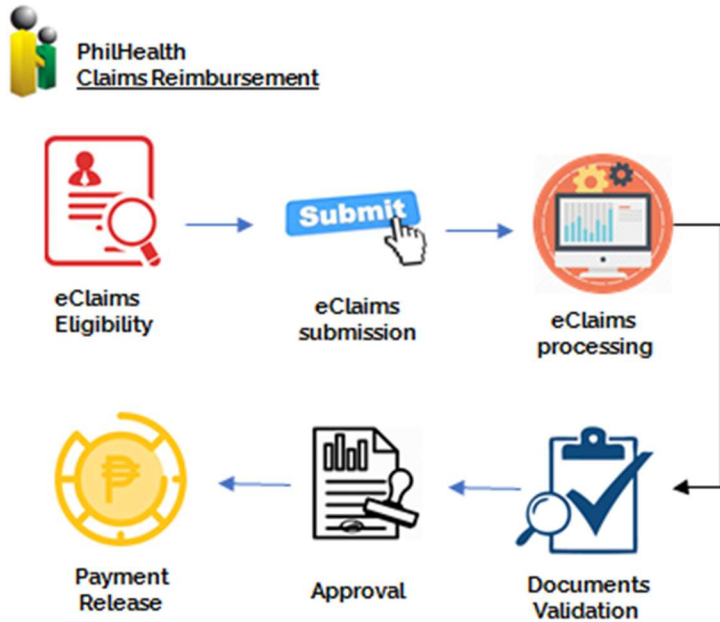


Figure 17. PhilHealth claims reimbursement process

Source: Graphic developed by ThinkWell Philippines, 2018

PhilHealth and Family Planning Services

The PhilHealth family planning package focuses on LARCs and includes permanent methods. The family planning package includes IUD and SDI insertion as well as BTL and non-scalpel vasectomy. PhilHealth does not make case-based payments for short term contraceptive methods (oral contraceptive pills, injectables, or condoms), which are either purchased out of pocket or procured by the national government and provided free of charge through public facilities. Aside from BTL, which is only available within hospitals, members may obtain all these services at the primary level in family planning-accredited public and private facilities. The PhilHealth family planning packages are to be delivered by accredited providers who have received prerequisite training for BTL, no-scalpel vasectomy, IUD insertion, and SDI insertion.

PhilHealth purchases family planning services for the same case-based rates from private facilities as from public facilities. However, the national family planning program provides commodities free of charge to public facilities while private facilities (or their clients) must generally purchase commodities. Notably, PhilHealth does not pay a separate rate for IUD and SDI removal; removal is included in the case rate paid for insertion. Table 1 provides additional information about PhilHealth purchasing of family planning services.

Table 1. Family planning service purchasing by PhilHealth

Service	Case Rate	Approved Location	Approved Provider
Bilateral tubal ligation	4,000 Php (\$77 USD)	Hospitals and ambulatory surgical clinics (ASCs)	Physicians
No-scalpel vasectomy	4,000 PHP (\$77 USD)	Hospitals and ASCs	Physicians
Intrauterine devices	2,000 Php (\$39 USD)	Hospitals, ASCs, RHUs, birthing homes, free-standing family planning clinics	Physicians, midwives, and nurses
Subdermal implants	3,000 Php (\$58 USD)	Hospitals, ASCs, RHUs, birthing homes, free-standing family planning clinics	Physicians, midwives, and nurses

Source: MCP Analysis of PhilHealth policies and circulars, ThinkWell Philippines, 2018

Although the number of private primary health care facilities accredited by PhilHealth is increasing, few of these facilities are accredited to provide family planning services. Figure 18 shows that the number of private birthing homes/lying in clinics accredited by PhilHealth has increased markedly since 2003 and has overtaken the number of accredited public RHUs. As of September 2017, PhilHealth had accredited over 3000 birthing homes/lying in clinics. While all these private facilities may in principle provide family planning services, they may only receive reimbursement for doing so if they are accredited specifically to provide family planning services. Figure 19 shows that the vast majority of these have been accredited to provide the MCP, but only a fraction of these MCP-accredited facilities have accreditation to provide and receive reimbursement for family planning services. This is notable because those facilities accredited to provide MCP services have only to complete a streamlined accreditation process, based on the acceptance of training certification, to receive reimbursement for family planning services. That so few MCP-accredited facilities opt to pursue this indicates a need to incentivize and facilitate family planning services accreditation so that these providers will expand their PhilHealth-reimbursed service offerings to include family planning.

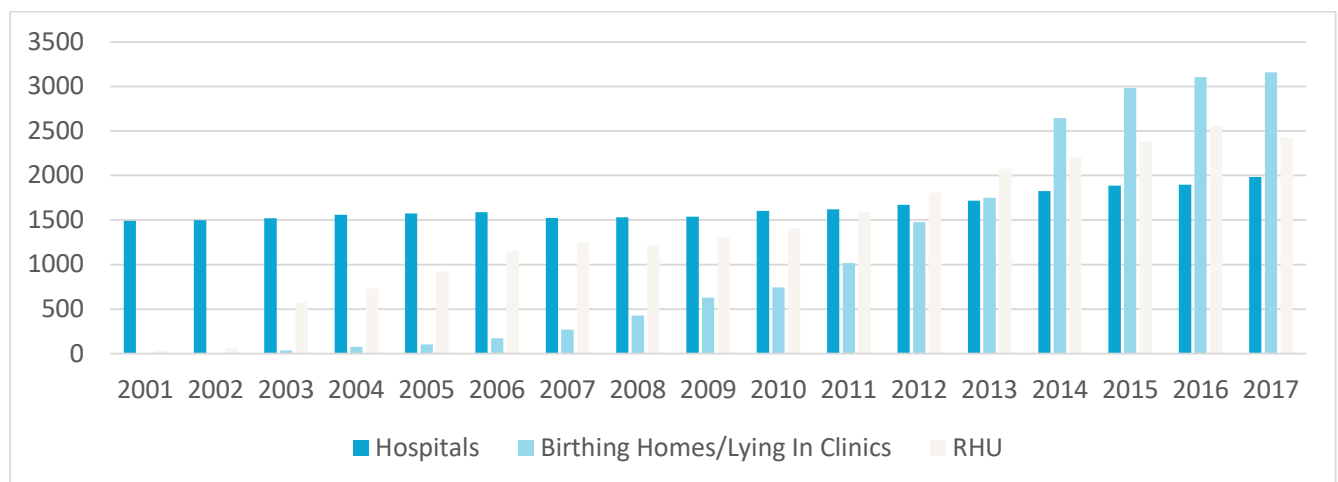


Figure 18. PhilHealth MCP accredited facilities (as of September 2017)

Source: Yason-Remonte 2018

Few providers have completed the trainings necessary to provide LARCs at an accredited facility. Before providing LARCs at a facility accredited to provide family planning, providers must complete trainings conducted by DOH-accredited training providers. Trainings accepted by PhilHealth include postpartum IUD (PPIUD), comprehensive, and SDI trainings. The Family Planning Competency-Based Training (FPCBT) is an introductory training that covers family planning counseling and is a prerequisite for SDI and PPIUD specific courses. Midwifery pre-service training introduces these skills but is not sufficient for PhilHealth accreditation. Figure 20 shows that very few providers nationwide have completed these trainings, which means that very few providers are technically eligible to provide these services within the accredited facilities. Figure 21 shows the current (June 2019) PhilHealth data on facilities accredited to provide LARCs. The low number of private facilities accredited to provide family planning combined with the paucity of providers who have completed the required trainings results in limited options for women who would prefer to access their family planning services in the private sector using their PhilHealth coverage.

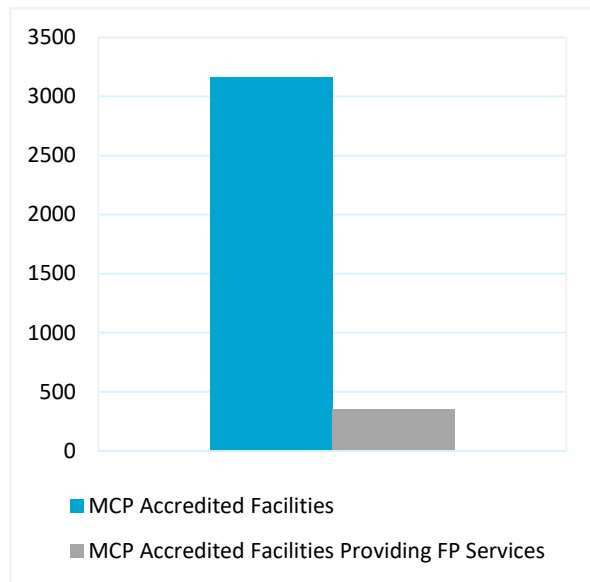


Figure 19. PhilHealth accredited private MCP facilities and MCP facilities providing family planning

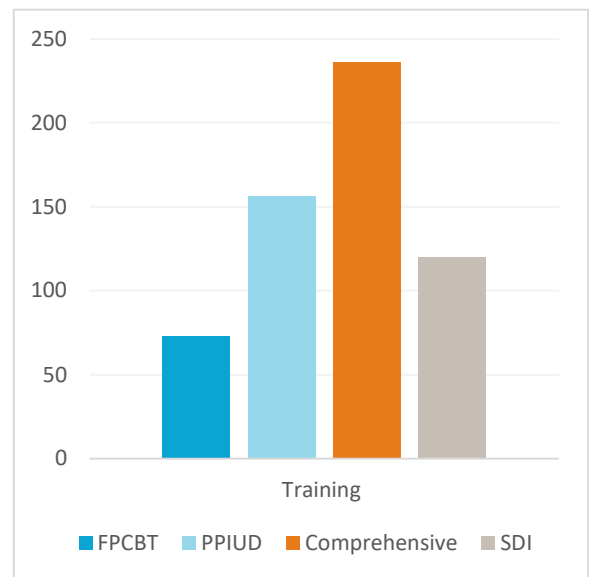


Figure 20. Professionals with PhilHealth approved family planning trainings

Source (both charts): Yason-Remonte 2018

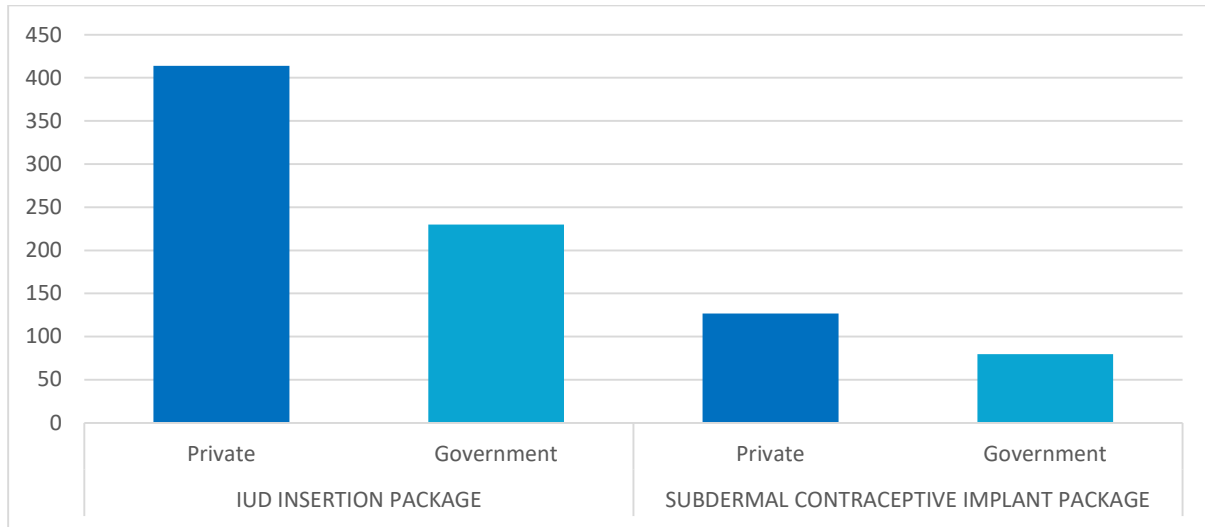


Figure 21. PhilHealth facilities accredited to provide LARCs, public vs. private sector, July 2019

Source: Analysis of PhilHealth claims data, received July 2019, ThinkWell Philippines

With few providers accredited, it is perhaps not surprising that PhilHealth receives few family planning claims. Figure 22 below shows LARC claims from all providers, based on claims data supplied by PhilHealth in mid-2019. IUD case-based payments were introduced in 2014, but claims are declining from a peak of a little over 5,000 in 2017. Implant claims have grown steadily since the introduction of a case-based payment rate in 2016, but the 17,000 claims in 2018 remain small in the context of more than 7 million women with an unmet need in the Philippines. The opportunity remains to accelerate growth, and in the sections below the reasons are explored as to why private providers are not engaging with PhilHealth on family planning.

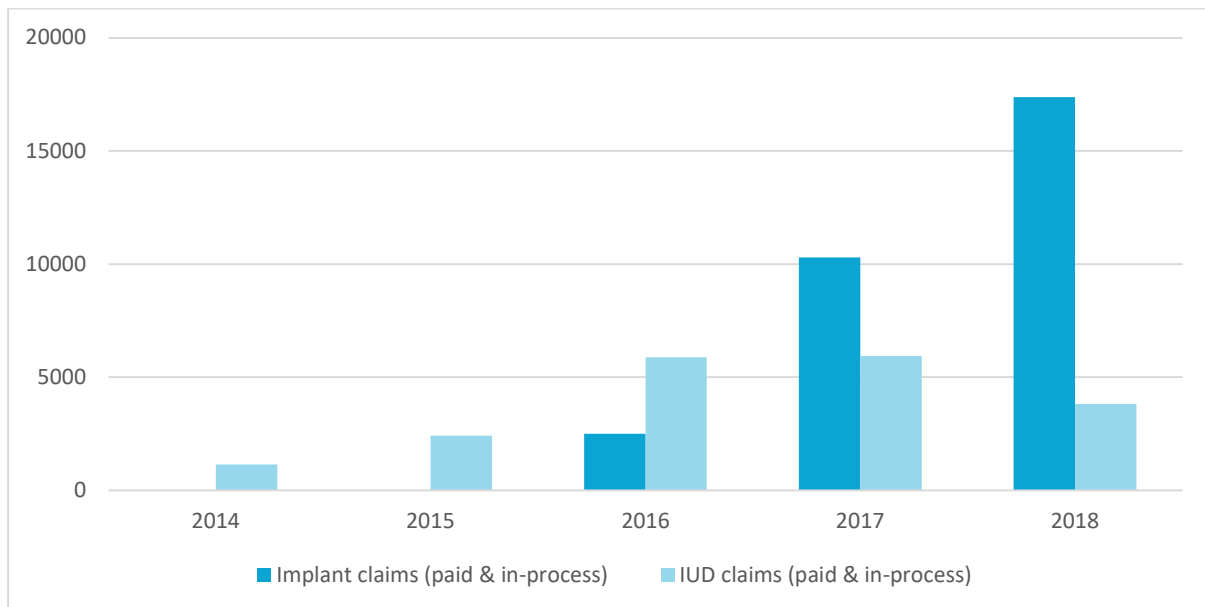


Figure 22. Long acting and reversible contraceptive (LARCs) claims, PhilHealth 2019

Source: Analysis of PhilHealth claims data, received July 2019, ThinkWell Philippines

V. MIDWIFE PERSPECTIVES ON PHILHEALTH AND FAMILY PLANNING

The value that PhilHealth offers to private providers will determine whether the purchaser is successful in influencing provider behavior. A strong value proposition has the potential to encourage providers to offer family planning counseling and services. Included is the value offered to providers by PhilHealth for family planning in terms of the balance between factors that add value (which would make offering family planning an attractive proposition for providers) and those that reduce value (which would discourage providers from offering family planning under PhilHealth).

Midwives working in the private sector identify several factors that reduce the value offered by PhilHealth for family planning services. These include perceptions of low profitability and arduous licensing and reimbursement processes. Underlying issues related to the professional identity of midwives further complicate the picture.

Low Profitability

Profitability is a primary consideration for private sector providers running their own businesses.

Fundamental to the value proposition of health insurance is the idea that providers will be reimbursed at a rate that allows them to increase net profit. This rate need not necessarily match prices charged for the same service; many other considerations, including, for example, expanding client base or increasing productivity, play an important role in profitability. Nevertheless, providers, particularly those who own and operate small businesses, are likely to at least compare insurance rates with typical prices charged to private clients. And it may be the perception of profitability, rather than profitability itself, that is critical to the value proposition.

PhilHealth established case-based payments for family planning and set the value of these payments, in a deliberate effort to encourage provision of family planning services. PhilHealth costed the provision of LARCs at three levels of service delivery: primary, secondary, and tertiary. To improve the value proposition, PhilHealth then decided to use only the highest cost, calculated for tertiary-level facilities, to set payment rates for all providers. These rates are significantly higher than those typical in other insurance schemes in middle-income countries; Indonesia's national health insurance (JKN) pays \$7 USD for an implant or IUD insertion, for example, while Ghana's National Health Insurance Scheme is piloting a similar rate.

However, the high price private providers must pay to buy contraceptives drives low profitability of PhilHealth family planning claims. Private providers typically pay approximately 3,000 - 4,000 PHP (\$57 - \$76 USD) to buy an IUD at a local pharmacy, and 4,000-5,000 PHP (\$76-\$95 USD) to buy an SDI. These costs exceed the reimbursement they receive from PhilHealth, even before other costs are considered. Professional fees charged in the private sector for LARC services range widely, from 300-3,000 PHP (\$6-\$57 USD).

Therefore, private providers in the Philippines do not see PhilHealth reimbursement for family planning services as a profitable business proposition. PhilHealth's case rates for LARCs are low compared to typical prices charged for providing the service that covers the product cost. PhilHealth reimburses 2,000 PHP (\$38 USD) for IUD insertion and 3,000 PHP (\$57 USD) for SDI insertion. By comparison, the prevailing market rate for IUD and SDI insertion is 4,000-5,000 PHP (\$76-\$95 USD) and 5,000-6,000 PHP (\$95-\$114 USD), respectively. Until 2017, private providers could charge copayments on top of their PhilHealth claim, but PhilHealth Circular 2017-006, which no-balance billing policy, now prohibits this for indigent and sponsored patients. There is no

“We get paid for inserting it [SDI] but not for removing it. Sayang sa oras [waste of time]!”

automatic provision to increase case rates; rates are not adjusted for inflation, and so they remain the same unless a review process is initiated. The last review of the MCP was in 2009, while family planning case rates were reviewed (but not changed) in 2018. Additionally, claims may be reimbursed for insertion but not for removal of IUDs and SDIs.

Ad hoc efforts to provide subsidized contraceptives to the private sector have not been sustained. The Philippines does not qualify for the global Implant Access Program, though which Merck Sharp & Dohme (MSD) and Bayer offer implants at a fixed rate of less than \$10 USD. The midwives’ association IMAP worked with MSD to offer reduced prices for its Implanon implant, but for a limited time only—this initiative does not appear to be sustainable. The temporary restraining order (TRO) prevented distribution of government

“If we get the commodities for free [from DOH] or at discounted prices, then we can provide the PhilHealth package easily. But if not, we would spend up to twice or thrice more [than what we would have earned] because the IUD or SDI can be very expensive. If we don’t have stocks, we either ask the patient to buy the commodity and then we do the insertion here. Or we just refer them to the rural health unit.”

purchased implants and following the lifting of the TRO, the government (including the Population Commission, PopCom) distributed large numbers of implants free of charge, even to non-government organizations and to the private for-profit sector. Now, however, this supply is gone and there are no plans to continue this offer. Figure 23 below shows the wide range of commodity prices and compares them to PhilHealth case rates. Small private midwives, especially away from Metro Manila and major cities, expect to purchase these commodities at the high end of this price range.

Family planning service	PhilHealth Case Rates in PHP (USD equivalent)	Private sector rates in PHP (USD equivalent)			
		Commodity Price	Insertion Fee	Ancillary Costs	Total
IUD Insertion	2,000 (40 USD)	800-4,000 (16-80 USD)	500-1,500 (10-30 USD)	1,100-1,500 (22-30 USD)	48-140 USD
Subdermal Implant Insertion	3,000 (60 USD)	1750-5,000 (35-100 USD)	1,000-2,000 (20-40 USD)	500 -1,000 (10-20 USD)	65 – 160 USD

Figure 23. Comparison of PhilHealth tariffs and private sector prices for LARCs

Source: ThinkWell market research, January 2018.

“For now, we [private providers] no longer receive free commodities from the government. Their focus is really on public facilities [to deliver family planning services] . . . There is no stopping them from imposing on us the same prices they offer to private OB-GYNs around PHP 3,500-3,750.”

PhilHealth case rates were not calculated to include the cost of commodities. The same rates are paid to public providers and private providers. PhilHealth assumed that commodities would be provided free of charge to all providers, public or private, through the national family planning program, or at a heavily discounted price through government and nongovernmental partnerships with distributors. However, in practice (and with few exceptions noted above) free commodities are provided only to public facilities and not to private facilities. Private sector midwives must purchase commodities individually and are generally unable to procure commodities at significantly lower than prevailing market prices. Very high market prices for LARCs perhaps reflect low volumes, but further investigation of the Philippine market and the potential to apply market-based solutions will be valuable.

Institutional responsibility for government subsidy of contraceptives remains unclear. This is, perhaps, the underlying cause of this disconnect between PhilHealth intention to offer strong value to private family planning providers and its failure to do so. However, structural changes in responsibility for contraceptive financing are likely. The development of implementing rules and regulations for the UHC Law includes discussion of responsibility for contraception and may offer opportunities to offer subsidy and improve access. This is discussed in the recommendations, below.

Currently, family planning service provision reimbursed through PhilHealth is seen as an unprofitable venture by private providers. Even when the opportunity presents itself, private sector midwives refer patients who are unable to pay high out-of-pocket prices to an RHU. There is very little financial incentive for private providers to navigate the process of accreditation with PhilHealth needed to claim for family planning services, and those who do so quickly find many barriers in their path. These are explored in more detail in the following section.

“I just refer them to the RHU because there, the IUD is free.”

Challenging Licensing, Accreditation, and Reimbursement Processes

Licensing

Few private providers undertake the arduous process of licensing and accreditation. In theory all providers, including midwives, must be licensed to practice in the Philippines. If this were enforced then, with licenses already in place, licensing might not be such a barrier to PhilHealth accreditation. However, because regulatory bodies do not routinely monitor or enforce whether private sector facilities have current licenses, many midwives consistently practice without meeting licensing requirements. This has obvious implications for service quality, as well as for purchasing arrangements.

Midwives first encounter challenges in attaining and maintaining the Professional Regulation Commission (PRC) License. By law, a practicing midwife must keep her PRC license (Figure 16, 1, above). Though the PRC license requirements appear straightforward, only 76,000 of an estimated 176,000 eligible midwives have renewed their PRC license in the past three years.² Renewal may be done online, but access to the internet is poor in rural areas throughout the Philippines. Travel to a regional center to renew the license in person is costly and time consuming. Because PhilHealth accreditation lapses when the PRC license lapses, PhilHealth is currently developing a prompt in their eClaims system that alerts users if a claim has been denied for this reason.

² Data from PRC are from an interview with Executive Director of IMAP, Mrs. Pat Gomez.

After a midwife has attained a PRC license, she may apply for PhilHealth professional accreditation (Figure 16, 2); the biggest barrier encountered by midwives at this point is completing the necessary family planning trainings. Midwives must complete additional specialized training on LARC provision from trainers designated by PhilHealth. While the DOH provides these trainings for free to providers at public facilities, private sector employees must schedule and pay for these trainings, most of which are conducted in Metro Manila once or twice a year. LARC trainings are not easily affordable for private midwives; one training may cost between 3,000-5,000 PHP (\$60-\$100 USD), participants must pay for their own travel and accommodations, and trainings entail substantial opportunity costs for the midwives. This is especially problematic for private midwives in geographically isolated and disadvantaged areas who may need to travel between islands for the training.

“Getting these trainings can be very expensive, especially for a small startup birthing home. And it’s not as if it’s a one-time investment, you have to do it every so often if you want to stay accredited. Apart from the training cost, we also need to shell out on travel and accommodation because we have to travel all the way to Manila because they don’t do trainings here.”

Until recently, private sector midwives needed to be accredited for the MCP before applying for family planning accreditation. For MCP accreditation, a midwife must secure an MOA to refer complicated pregnancies to either an accredited partner physician, interlocal health zone, or a BEmONC-CEmONC network. This requirement is redundant, as an accredited facility must also have this MOA. The MOA has become a barrier to attaining the PhilHealth professional accreditation because some midwives think that they need to have an MOA with all local facilities when in fact they only need an MOA with one.

The next step, attaining the DOH-LTO, presents the most significant challenges to private sector midwives aiming to receive PhilHealth reimbursements for birthing homes (Figure 16, 3). The cost burden of attaining the DOH-LTO is high for these small businesses. For a first-time application for a new facility, fully complying with the DOH-LTO requirements costs approximately 1.5 million PHP (\$28,000 USD). This includes construction costs, securing the necessary business permits, and completing registration with the Department of Trade and Industry (DTI) and the Department of Environment and Natural Resources (DENR), attaining certification from the Bureau of Internal Revenue (BIR), and securing a mayor’s permit. In contrast, according to midwives, a birthing home can be constructed and operations commenced without regard for the DOH licensing requirements for approximately 550,000 PHP (\$10,000 USD).

Midwives who own birthing homes may easily continue operating without a DOH-LTO. Weak enforcement capacity within the DOH and city and municipal health offices means that birthing homes operated without an LTO are only sanctioned if the LGU receives serious reports or complaints, such as maternal or newborn deaths. Even then, sanctioned facilities can resume operations easily as a new entity under a different business permit.

“Accredited or not, licensed or not, it doesn’t really matter, especially to the patients, as long as you accommodate them, delivery quality, and don’t overcharge. And the authorities won’t know anyway, unless somebody dies or complains.”

DHO-LTO requirements are complex, and midwives often lack a thorough understanding of and compliance with these requirements. This lack of understanding may prevent private sector midwives from applying for and/or attaining the DOH-LTO. Some noncompliant facilities do attain their DOH-LTO, however, generally where issuance is intended to improve access to MNCH and FP services. Once a birthing home has attained a DOH-LTO, getting the PhilHealth MCP facility accreditation poses less of a challenge. PhilHealth has tried to allow flexibility for private sector facilities to be licensed but has not made significant progress; licensing requirements fall within the jurisdiction of the DOH, which is reluctant to loosen criteria and risk that this could be perceived as being lax on quality.

“I don’t understand how complying with all of this translates to less maternal mortality and better quality care.”

Free-standing family planning clinic accreditation is very new, and private sector midwives have little familiarity with this opportunity. While the DOH free-standing FP certification process is streamlined to exclude the spacing requirements of the birthing home DOH-LTO, there remain time-consuming and potentially costly requirements. Given the challenges that private midwives face in making a profit from PhilHealth family planning case rates, it seems likely that buy-in from private midwives to establish free-standing family planning clinics will remain limited. As of December 2018, PhilHealth had not certified any free-standing family planning clinics.

“We don’t know how it [the free-standing family planning clinic] works. What will the processes be like?”

Claims Reimbursement

Midwives complain that payment of PhilHealth claims is uncertain and often delayed. A lack of transparency in communication from PhilHealth means that, when payments are received, it is often unclear which claims have been paid (in whole or in part), which rejected, and which are still in process. PhilHealth updates its rules and regulations by issuing circulars, many of which include important information for providers seeking to claim. These are now available on the PhilHealth website (<https://www.philhealth.gov.ph/circulars/>). This is an important step, but few private providers, particularly private midwives, will have the capacity or resources to read and understand all circulars, and finding relevant information remains challenging. Reasons for rejecting claims are rarely given, leaving providers uncertain what mistakes they have made, and reducing the potential for PhilHealth to improve provider claims performance through an iterative feedback and learning process.

“All of these requirements, it’s as if they just want to make our lives and livelihood difficult. Why can’t they simplify the processes and requirements or provide assistance at least especially for those who are new and unfamiliar with how things work? Most of the time, the instructions are also unclear and confusing. Somebody says this but when we return and talk to someone else, we get a different answer.”

PhilHealth may struggle to balance the competing imperatives of controlling costs and supporting providers to submit correct claims. Some respondents have surmised that private providers' claims are given low priority in claim processing due to perceptions that public funding of private health care is inappropriate.

Using the new PhilHealth eClaims system remains a challenging process for private sector midwives. The eClaims system is an important step forward for PhilHealth and does facilitate claims eligibility analysis, submission, processing, status verification, and reimbursement. However, the claims submission process is difficult for many private sector midwives. Few facilities owned by private sector midwives have the capital or technical expertise to develop their own software, and many private sector midwives lack the computer literacy skills to use the software provided by the HITP technology providers. Midwives must thus hire IT staff, constituting an additional expense. Internet is often inaccessible and unstable to facilities in remote or resource-poor settings, making it challenging for facilities and HITPs alike to send the claims via internet. Once submitted, claims processing is further delayed by the unstable and slow internet in the Philippines. Server breakdown is the primary cause of delay in submission, processing, and claims reimbursement. Finally, while most claims forms are encoded and thus legible to adjudicators, Claims Form 3, which includes the patient's clinical record, is commonly used by midwives and must be filled out by hand, scanned, and sent to PhilHealth.

"It is so hard to use the e-Claims system, especially here at our province. During rainy season, the internet gets unstable and we cannot submit claims. And when the internet is good, we also still cannot submit claims because their server is not working."

"I used to be accredited by PhilHealth but it's easier for me to provide the family planning services without it because I get paid ASAP. Even if the patient cannot pay [out-of-pocket] in full, I make them sign a promissory note and they pay after a month or so. With PhilHealth, the [claims reimbursement] takes from two to six months even with the new e-Claims system. Most of the time, it even gets denied."

This makes it particularly prone to illegibility and subsequent return or denial.

Professional Identity

Private sector midwives tend to define their professional role as centered on attending deliveries rather than providing family planning services. This perspective may limit not just their willingness to pursue PhilHealth accreditation but also their intentions to provide family planning services at all. In the focus group discussions conducted, a variety of issues arose around this topic.

Some midwives, particularly mid- and late-career midwives, may feel reticent to provide family planning services due to their own deeply held religious convictions. Social norms around contraception have changed rapidly over the last decades, with DHS data suggesting that opposition to using contraception dropped from 19.7% of Filipino non-users in 2003 to 9.6% in 2008, and to only 1.6% in 2013. This is in part a generational change, and older midwives are less likely to be comfortable offering contraception at all, in particular to unmarried women.

"We [younger midwives] are more liberal compared to the older ones who are less likely to provide contraception."

Some midwives said that their training prepared them to deliver babies rather than to prevent them. The non-inclusion of family planning counseling and service delivery in pre-service training is likely linked to social norms. Nevertheless, pre-service training is critically important in expanding the range of family planning methods available, and a review of standard midwife training curricula could provide useful additional information. The time may be right to advocate for standardization and the inclusion of more practical FP training in midwifery curricula.

“I am a midwife, I was trained to facilitate birth, not to prevent it.”

Private midwives’ business models are based on delivering babies. Midwives voiced that they felt much more familiar with the business of running a birthing facility but, because of limited exposure, would not feel inclined to provide family planning options. Providing family planning may not only be unfamiliar but can be seen as directly undermining this business model: more contraception, fewer babies, fewer deliveries, less business. Busy service providers with limited time generally prefer providing the maternal care package, which is also seen as more directly profitable than the family planning package. That relatively few MCP-accredited facilities are accredited by PhilHealth to provide family planning services, despite the relatively simple process of adding FP accreditation, suggests that private sector midwives simply opt not to provide family planning services but would rather prioritize MCP services.

Finally, private midwives know that rural health units provide family planning services for free. Without compelling reasons otherwise—whether financial or altruistic—they consider it the rural health unit’s role, rather than their role, to provide family planning, and happily refer patients across.

“If it was me, I’d rather just deliver births. We earn so much more. It’s more value for the time and effort we pour.”

“Giving birth is our bread and butter.”

VI. DISCUSSION AND RECOMMENDATIONS

The Philippines has strongly committed to increasing access to family planning services and removing financial barriers to women seeking them. The government has illustrated this by passing the Universal Health Care Law, implementing the RPRH Law, articulating the importance of family planning in the Philippine Development Plan 2017-2022, and signed on to numerous international initiatives. Increasing access and removing financial barriers to family planning services, LARCs in particular, will increase mCPR and ultimately result in positive development outcomes. Global evidence strongly supports midwife-led provision of family planning services, and private midwives are a trusted source of reproductive health services provision in the Philippines. PhilHealth can leverage this to increase access to family planning services by expanding the number of private birthing homes and free-standing family planning clinics accredited by them to provide family planning services.

Private providers face numerous challenges that limit the number of private facilities accredited by PhilHealth. Private-sector midwives say that reimbursement for providing family planning services is insufficient, licensing and accreditation processes are expensive and complicated, and reimbursement is

difficult to access. Some midwives also view their role as primarily related to attending births rather than to providing family planning services. Below are options for addressing these challenges.

1) Family planning and the UHC Law

Under the UHC Law, government health financing in the Philippines will be divided between “individual-based services” and “population-based services.” “Individual-based services” (health care services whose benefits can be traced to one individual) will be financed by PhilHealth. “Population-based services” (health care services with externalities that benefit more than one individual) will be financed by the LGU and/or by DOH.

If family planning is classified as a “population-based service,” the Philippine government will limit its potential to effectively engage private providers to increase FP access. The DOH does not currently have mechanisms to contract with small-scale private providers, and history suggests that it is unlikely to prioritize this approach. The DOH can certainly take on important work to improve family planning access and quality through the public sector, to more effectively procure and supply contraceptives (including potentially offering subsidized contraceptives to private providers), ensure effective inclusion of family planning in pre-service training, and work on social behavior change around contraception. But the DOH is unlikely to directly contract private providers to improve FP access.

Recommendation: UHC implementing rules and regulations (IRR) planning teams should carefully consider classifying FP services requiring clinical intervention, including implants, IUDs, and injectable contraceptives as individual-based services. This classification would maximize the long-term opportunities associated with PhilHealth contracting of private family planning providers. Case-based payments for these methods through PhilHealth would also have the potential to encourage provision and improve access and choice. Other components of FP programming, such as training, health communication, and surveillance, could be classified and funded as population-based services through the DOH.

2) Case-based payment rates for LARCs

Contraceptive product costs make PhilHealth’s current case-based payment rates for LARCs unprofitable for private providers. Profitable rates are the starting point to effectively engage private providers, opening the potential for improving access to family planning services. To ensure that rates are appropriate, the design and rollout of benefit packages, payment, and claims mechanisms should consider private sector perspectives. Developing packages and adjusting case rates should consider the feasibility of these packages among private providers and the various scenarios they find themselves in (urban vs. rural, primary care vs. higher-level care, small-scale vs. large-scale operations).

To increase profitability of private sector family planning claims, either contraceptive prices need to be reduced, or payment rates need to increase. Developing a more comprehensive primary care benefits package under the UHC IRR, as well as associated costing and rates revision, presents an opportunity to consider where case-based payments make most sense and to review associated rates. Responsibility for contraceptive financing, procurement, and supply management in the Philippines is also under review and keenly debated, with the role of the former Population Commission (PopCom), now redesignated Population and Development Commission (PopDev) and potentially playing a role in contraceptive supply, just one example of a rapidly changing context.

Recommendation: PhilHealth and other stakeholders should review case-based payment rates for LARCs in collaboration with private sector providers, taking into account the cost of contraceptives. Consideration should be given to the provision of free or subsidized contraceptives to the private sector, perhaps associating access with PhilHealth accreditation. Stakeholders may also consider differential case-based payment rates between public sector (receiving commodities free of charge) and private providers (responsible for

purchasing their own contraceptives). ThinkWell can support these efforts through further investigation into the market for LARCs to better understand what drives high prices in the Philippines.

3) Time-consuming and costly licensing and accreditation processes

Time-consuming and costly accreditation and licensing procedures prevent and discourage private midwives from pursuing PhilHealth accreditation. The numerous steps required to attain both professional and facility-level licensing and accreditation result in substantial financial and opportunity costs for private-sector midwives. Although by law providers may not practice without the mandated licenses, limited enforcement capacity makes it common practice to run a successful business without them. Midwives voice the importance of providing high-quality services and running a viable business, and they perceive that investing in licensing and accreditation translates neither to better service quality nor to increased profitability. Ultimately, licensing and accreditation mechanisms and associated marketing and communications strategies should go beyond traditional guarantees of affording prestige or increasing customer patronage to demonstrate the linkages between licensing, accreditation, quality, and, eventually, profitability.

Recommendation: DOH, PhilHealth, and other stakeholders might consider exploring opportunities to streamline, standardize, and rationalize accreditation and licensing requirements for provision of PhilHealth MCP and family planning packages. Redundancies and conflicts between different institutions and the licensing, accreditation, and certification processes could be identified and reconciled through institutional, intersectoral, and interagency dialogue. Such dialogue could inform subsequent process review and rationalization. Streamlining of processes for providers would facilitate communication, monitoring, and enforcement among providers, patients, and regulatory bodies. It would be particularly valuable to identify and resolve redundancies between professional accreditation of private midwives and facility accreditation of birthing homes. For example, it could be possible to consolidate currently separate MCP and LARC accreditation into just MCP, or at least integrate family planning counseling and referral into MCP accreditation.

4) Delayed reimbursement

The recently introduced eClaims system has hastened the process of claims reimbursement. However, processing redundancies, lack of technological infrastructure, and unresponsive prompts on payment status lead to payment delays. A lack of easily accessed and understood PhilHealth rules and regulations discourages provider engagement. Communications around the claims process, including explanation of claim rejection, can be strengthened.

Recommendation: To reduce reimbursement delays, PhilHealth should continue to invest in digitalizing all its claims form and claims reimbursement processing requirements. Specifically, PhilHealth, learning from its implementation of the electronic CF4 claims system, could develop a software module for Claim Form 3 to reduce claims returns and denials due to blurred scans and illegibility. The cost-benefit of using electronic signature pads should be explored; this can help avoid the redundancy of uploading paper documents that are also encoded electronically as claim forms. Additionally, PhilHealth investment in server capacity will ultimately reduce the frequency of server malfunction. This would also lead to faster response time when resolving claims errors. Finally, enabling more detailed claims error notifications, such as those prompted in the case of PRC license lapse, would enable midwives to address claims errors more expediently. Partnership between private midwives association and an e-Claims software company or HITP might also be explored; the goal is to create a simple, streamlined application for MCP (including FP), helping to reduce costs to individual midwives by offering a simple, cost-effective solution.

5) Professional identity

Midwives continue to identify as birth attendants rather than as providers of family planning services. This cognitive dissonance experienced by private midwives may be addressed by pursuing reforms in the

preparation of and continuing professional development for health professionals. Pre- and in-service training should place increased emphasis on the continuity and complementarity of family planning and maternal health services. Increased access for private providers to the trainings required by PhilHealth prior to providing the MCP and FP packages could stimulate service delivery, improve quality, and encourage providers to reconsider their professional identity.

Recommendation: DOH should strategize about increasing human resource capacity for family planning services. DOH should prioritize ways to provide in-service trainings that are financially accessible to private providers, including midwives. These trainings should satisfy both the continuing professional development requirements and the PhilHealth training requirements, particularly for FPCBT 2 and SDI insertion and removal. Midwives will learn the necessary skills to provide FP services and thus be eligible to receive claims reimbursement. In the future, the pre-service midwifery curriculum could be revised to include the FPCBT 2 and SDI training requirements so that additional training would no longer be necessary.

6) Service delivery networks

As the UHC Law is implemented, PhilHealth will contract with service delivery networks rather than with individual providers. Health care provider networks will be designed to ensure effective geographical coverage, facilitate referral between levels of service provision and between general and specialist providers, and drive efficiency by institutionalizing gatekeeping functions. Networks hold the potential to increase economies of scale, lower procurement costs of commodities, and improve administrative efficiency. They may be composed of public, private, or mixed facilities at all levels of health care. Detailed contracting arrangements are being developed through a roll-out of UHC provisions in selected UHC integration sites.

Recommendation: The government should consider and test the inclusion of small-scale private providers (including midwives and other providers of family planning and MNCH services) within health care provider networks. Networks should contract private providers and connect their practices with government-provided family planning and MNCH service delivery systems. Government-supported network provision of family planning and MNCH services is advantageous for poor women; it increases their options, access, and ability to navigate family planning and MNCH services. But it may also lead to efficient utilization of limited resources (financial, human, knowledge) by allowing for integration of efforts and sharing of resources between the public and private sector (e.g., pooled procurement of family planning and MNCH commodities that maximize volume purchasing, sharing of ambulances and emergency equipment, and sharing of IEC materials).

VII. CONCLUSION

The supply of family planning services has not kept up with demand in the rapidly evolving social context of the Philippines. Political commitment to improving access to family planning is high, and is reflected in policy and regulatory changes. The UHC Law will radically reform the Philippines health sector in the coming years. This reform presents the opportunity to dramatically improve access to family planning by leveraging a vibrant private reproductive health sector that currently offers highly limited clinical family planning services. PhilHealth contracting of private providers has the potential to expand the number of family planning service delivery points, to improve the quality of services, and to increase the choice of family planning methods available at each site. This report presents a series of recommendations that can help make this potential a reality, and ThinkWell will continue to work with partners in PhilHealth, DOH, and elsewhere to develop, test, and learn from these interventions.

GLOSSARY

Note: The use of terms included in this glossary varies across contexts. Definitions provided here reflect meaning and use in the Philippine context. Note that terms are organized thematically rather than alphabetically. This glossary includes terms pertinent to this scoping review and is not exhaustive.

License

Professional Regulation Commission License

A permit conferred to a professional (e.g., midwife) by the Professional Regulation Commission upon successful completion of a standardized examination that tests the technical competency of the professional. The Professional Regulation Commission is a national government agency mandated to enforce the laws regulating the various professions, including midwifery.

Department of Health-License to Operate (DOH-LTO)

A formal authority issued by the Department of Health to an individual, agency, partnership, or corporation to operate a hospital or other health facility. It is a prerequisite for accreditation of a health facility by any DOH-recognized accrediting body for Quality Management System, such as an international organization for standardization (ISO).

Permit

Department of Health-Permit to Construct (DOH-PTC)

A permit issued by the Department of Health through the Health Facility and Services Regulatory Bureau to an applicant who will establish and operate a hospital or other health facility, upon compliance with required documents prior to the actual construction of said facility. A DOH-PTC is also required for hospitals and other health facilities with substantial alteration, expansion, renovation, increase in the number of beds, or additional services (add-ons) beyond their service capability. It is a prerequisite for the Department of Health-License to Operate.

Barangay Clearance/Permit

Clearance from a barangay to locate or conduct business in said barangay. This permit is a prerequisite to the city or municipality license or permit.

Mayor's / Business Permit

The business permit is issued by the municipality and signed by the mayor. The documentary requirements are as follows: proof of payment for the permit, income statements, contract of lease, barangay clearance, zoning clearance, sanitary / health clearance, occupancy permit building official, and fire safety inspection certificate, among others.

Certification

Department of Health Certification of Free-Standing Family Planning Clinic

The process wherein the Department of Health Regional Office assesses and evaluates whether a free-standing family planning facility has met the standards for quality set in the Department of Health Administrative Order 2017-0002.

Certificate of Compliance (COC)

A form of authorization/permission granted by the Food and Drug Administration that serves as proof of the facility's compliance to the set technical requirements. It is a prerequisite for the issuance of the Department of Health-License to Operate.

Accreditation:

Individual Professional Accreditation

A process overseen by PhilHealth whereby the qualifications and capabilities of health care providers (physicians, dentists, midwives, registered nurses) are verified in accordance with the guidelines, standards, and procedures set by the Corporation.

Institutional Accreditation

A process overseen by PhilHealth whereby the qualifications and capabilities of health care facilities (hospitals; ambulatory surgical clinics; free-standing dialysis clinics; rural health units/health centers as providers of the Outpatient Benefit Package for sponsored members of PHIC; maternity care clinics for low risk, normal spontaneous deliveries; anti-TB/DOTS clinics) are verified in accordance with the guidelines, standards, and procedures set by the Corporation.

REFERENCES

- Bradley, Sarah E.K., Hilary Schwandt, and Shane Khan. 2009. "Levels, trends, and reasons for contraceptive discontinuation." *DHS Analytical Studies* 20.
- Cahill, N., Sonneveldt, E., J. Stover, M. Weinberger, J. Williamson, C. Wei, W. Brown, and L. Alkema. 2018. "Modern contraceptive use, unmet need, and demand satisfied among women of reproductive age who are married or in a union in the focus countries of the FP 2020 initiative: a systematic analysis using the Family Planning Estimation Tool." *The Lancet* 391: 870-882.
- Campbell, O. et al. 2016. "Family planning, antenatal and delivery care: cross-sectional survey evidence on levels of coverage and inequalities by public and private sector in 57 low- and middle-income countries." *Tropical Medicine & International Health* 20 (12) 1639-1656.
- Cico, A., Laird, K., Tarantino, L. 2018. "Defining institutional arrangements when linking financing to quality in health care: A practical guide". Bethesda, MD: Health Finance and Governance Project , Abt Associates Inc.
- Committee on Population and Family Relations. 2011. "House Bill 4244." Committee Report 664, Republic of the Philippines, House of Representatives, Quezon City.
http://www.congress.gov/download/basic_15/HB04244.pdf. Accessed May 27, 2019.
- Dayrit, M.M., L.P. Lagrada, O.F. Picazo, M.C. Pons, and M.C. Villaverde. 2018. *The Philippines Health Systems Review*. Vol. 8. 2 vols. New Delhi: World Health Organization, Regional Office for South-East Asia.
- DHS Program. 2019. *STATcompiler*. <https://www.statcompiler.com/en/>. Accessed May 27, 2019.
- Gomez, Ms. Pat, interview by Dr. Gelo Apostol. 2019. *Executive Director, Integrated Midwives Association of the Philippines* (May 20).
- Halpern, Vera, Lauren M. Lopez, David A. Grimes, Laurie L. Stockton, and Maria F. Gallo. 2013. "Strategies to improve adherence and acceptability of hormonal methods of contraception." *Cochrane Database of Systematic Reviews* 10 (2013) 10.
- ICF, Philippine Statistics Authority (PSA). 2018. *Philippines National Demographic and Health Survey*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.
- Lipetz, Clare, Ceri J. Phillips, and Charlotte F. Fleming. 2009. "The cost-effectiveness of a long-acting reversible contraceptive (Implanon®) relative to oral contraception in a community setting." *Contraception* 79 (4): 304-309.
- National Population and Family Planning Board, Statistics Indonesia, Ministry of Health and ICF. 2018. "Indonesia Demographic and Health Survey 2017" Jakarta, Indonesia: National Population and Family Planning Board, Statistics Indonesia, Ministry of Health and ICF
- National Statistics Office and ORC Macro. 2004. "National Demographic and Health Survey 2008" Calverton, Maryland: National Statistics Office and ORC Macro
- National Statistics Office and ICF Macro. 2009. "National Demographic and Health Survey 2003" Calverton, Maryland: National Statistics Office and ICF Macro
- Obermann, Konrad, Matthew Jowett, and Soonman Kwon. 2018. "The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis." *Global Health Action* 11 (1): 1483638.

- PhilHealth. 2018. "2017 Stats & Charts." *PhilHealth*.
https://www.philhealth.gov.ph/about_us/statsncharts/snc2017.pdf. Accessed May 15, 2019.
- Philippine Statistics Authority and ICF International. 2014. "Philippines National Demographic and Health Survey 2013" Manila, Philippines, and Rockville, Maryland, USA: Philippines Statistics Authority and ICF International
- Philippine Statistics Authority and ICF. 2018. *Philippines National Demographic and Health Survey*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.
- Ross, J., and J. Stover. 2013. "Use of modern contraception increases when more methods become available: analysis of evidence from 1982-2009." *Global Health Scientific Practice* 203-212.
- Ross, J., K. Hardee, E. Mumford, and S. Eid. 2001. "Contraceptive method choice in developing countries." *International FP Perspectives* 28 (1): 32-40.
- Sobel, H. 2018. "Underlying causes of unmet need in Philippines." WHO presentation at Workshop on Strategic Actions for Key Family Planning Players, Manila, Philippines, January 2018.
- Steiner, Markus J., James Trussell, Neha Mehta, Sean Condon, Sumathi Subramaniam, and Deborah Bourne. 2006. "Communicating contraceptive effectiveness: A randomized controlled trial to inform a World Health Organization family planning handbook." *American Journal of Obstetrics and Gynecology* 195 (1): 85-91.
- Stoddard, A., C. McNicholas, and J.F. Peipert. 2011. "Efficacy and safety of long-acting reversible contraception." *Drugs* 71 (8): 969–980. doi:doi:10.2165/11591290-000000000-00000.
- UNFPA. 2017. *Executive Order sets new momentum for RPRH Law*. January 12.
<https://philippines.unfpa.org/en/news/executive-order-sets-new-momentum-rprh-law>. Accessed May 15, 2019.
- Weinberger, M., and S. Callahan. 2017.(a) *The Private Sector: Key to Reaching Young People with Contraception*. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Project, Abt Associates.
- WHO Regional Office for South-East Asia. 2016. *Family Planning in South-East Asia Factsheets 2016*. Accessed May 24, 2019. http://www.searo.who.int/entity/maternal_reproductive_health/documents/family-planning/en/.
- WHO. 2017. "Family Planning Evidence Brief – Partnering with the private sector to strengthen provision of contraception." *World Health Organization*
- WHO Regional Office for South-East Asia. 2018. *The Philippines health system review*. Health systems in transition. Vol 8. No 2 on behalf of the Asia Pacific Observatory on Health Systems and Policies.
- Yason-Remonte, M.A. 2018. "Catalyzing Efforts and Partnerships to Accelerate Access to Family Planning after the Temporary Restraining Order." *National Brainstorming and Workshop on Strategic Actions for Key FP Players*. Manila.