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JOINT MANIFESTATION ON PHIC CIRCULAR 011-2011

Respectfully, immediate temporary suspension of the implementation of PHIC Circular 011-2011 is in order.

Last September 10, 2011, the Philippine Medical Association (PMA), the Philippine Hospital Association (PHA) and the Private Hospitals Association of the Philippines (PHAP) came together for an urgent joint meeting to take up the matter of the PhilHealth Circular No. 011-2011 issued by the PHIC on August 5, 2011. Also in attendance were: (1) Specialty Societies (i.e. Philippine College of Surgeons, Philippine Obstetrics and Gynecology, Philippine College of Physicians, Philippine Society of Anesthesiology, Philippine Society of Pathologists, Philippine College of Ophthalmology), (2) Metro Manila Councils of the Philippine Heart Association, (2) Metro Manila Chapters of the Private Hospital Association of the Philippines, and (3) the Component Medical Societies of the PMA (Manila Medical Society, San Juan Medical Society, Quezon City Medical Society). On page 3 of the Circular, under Chapter III, it is thus printed – “A. The No Balance Billing (NBB) Policy shall be applied to all Philhealth Sponsored Program members and/or their dependents for the above specified cases and under any of the following circumstances: (1) *when admitted in government hospitals/facilities* (italics ours); . . .”.

Last September 7, 2011 on ANC Channel hosted by Karen Davila (shown again in the evening of September 10, 2011), and on teleradyo “*Dos-For-Dos*” last September 9, 2011, unwittingly, the PHIC made pronouncements that were not quite clear to the viewers to the effect that the PHIC Circular 011-2011 is likewise “applicable to the

private hospitals". This has elicited incessant calls from different regions to the Offices of the PMA, PHA and the PHAP asking for clarifications.

The PMA, PHA and the PHAP have also noticed that in the publication of the same Circular in some newspapers (Bulletin Today, Philippine Star, etc) there is no clear indication that the Circular will be applied only to government hospitals starting September 1, 2011 as this was the previous agreement between the PHIC and PHA and PHAP.

These events have created a perception on the viewers that there is variance between your pronouncements and the newspaper publications and the circular itself. In the light of the situation, The PMA, PHA and the PHAP would like to request your good Office immediately for a written *memo* or circular stating distinctly that "PhilHealth Circular No. 011-2011 dated August 5, 2011 which was made effective September 1, 2011 is APPLICABLE ONLY TO GOVERNMENT HOSPITALS".

In the long run, PHIC Circular 011-2011 will be made to apply to private hospitals and to private medical practice. Lest it be misunderstood by the public, PMA, PHA and the PHAP are likewise committed to helping the most indigent of our brethren. We are supportive of the noble undertaking of the PHIC as it is aligned with the Universal Health Coverage Program of His Excellency, President Benigno "*Noynoy*" Aquino even as we also believe that this will be beneficial to all Filipinos, specially the most marginalized sector of our society. However, if the PHIC Circular 011-2011 will be made to apply to the private hospitals and to private medical practice, we must together, as partners, make it sure that the program is viable and that the program is really in favor for its intended beneficiaries, and that its beneficiaries are not shortchanged in the health care that they fully deserve under the program, and also importantly, that the funds are really well spent to the truly most indigents of our society.

During the joint meeting of the PMA, PHA and PHAP on September 10, 2011, the following core issues in connection with the NBB policy and Case Rate Payment schemes were thus discussed:

1. Whether or not the beneficiary under the NBB Policy and the Case Rate Payment scheme really gets the full health service required by his or her medical condition;
2. Whether or not this program of NBB Policy and the Case Rate Payment scheme can be sustained to its end;

3. Whether or not the quality of health care service that the beneficiary deserves will suffer under the NBB Policy and the Case Rate Payment scheme;

Of course side by side with the above core issues are corollary ones like, for example, the question of why would a referring hospital be denied of its claim in favor of the second hospital to which the patient is finally referred and still other issues which are but mostly the confusion brought about by the Circular, thus please allow us to dwell on the core issues as follows:

The issues are best discussed with a concrete example. In the case of Dengue I and II where the rate is pegged at P8,000.00 and P16,000 pesos respectively, no one knows which patient is going to experience bleeding in which case transfusion of blood or blood products is required 3 or 4 times and not even considering the cost of the required laboratory examinations to monitor the patient's bleeding. The price of blood and blood products range from P2,000.00 to P4,000.00 and the price of the laboratory examinations range from P300.00 to P1,000.00. The request for laboratory examinations may not be less than 4 times. The cost of all of these will be the burden of the hospital without realizing profit precisely because of the commitment of the hospitals to serve the indigents and this is not considering the professional fees of the doctors who will serve the patient for the sake of charity. But how long could the hospital sustain the cost of this program and how about those whom the hospital shall pay in terms of salaries? How about the supplies that the hospital shall purchase for the operation of the hospital? Will the hospitals be allowed to increase the price of its services to be billed on other non-Philhealth patients or other non-indigent Philhealth patients?

Ultimately, the program will drain the coffers of the hospital and if drained, hospitals beyond their control, could no longer fully serve the next group of indigent patients. The hospital will be forced to downgrade its services if only to accommodate the next group of indigent patients. The hospital will ask its doctors to use re-usable needles and syringes as well as non-absorbable sutures. In other words, the program will push back hospitals and medical practitioners to *jurassik* practices and thus depriving the indigents their full and well deserved quality health care. Instead of blood transfusion, the hospital is forced to give the patient Saline solution because the hospital could no longer afford to purchase blood precisely because its coffers are drained during the confinement of the previous indigent patients. The hospital is thus placed in an ethical issue of allocating its services and resources to the indigent patients. The hospital and doctors are placed in this ethical question- "Given a fixed budget of a hospital under the NBB

Policy and Case Rate Payment scheme and with the present cost of hospital supplies, which is ethically feasible, few indigent patients will receive full health care service, or most number of patients will receive less full health service?”. Stated otherwise, given a budget of P100 pesos for one to distribute to hungry, indigent persons for food, which is ethically acceptable, P10 pesos each for 10 persons, or P50 each for 2 persons. This is exactly the situation where the NBB Policy and Case Rate Payment Scheme of PHIC places the hospital and the doctors. Ultimately, the hospital is left with no choice but to choose the second situation considering the number of indigents that would flood the hospitals and to be served by the doctors. The indigent patients in the long run are thus underserved under this PHIC scheme and are shortchanged. Respectfully in layman’s understanding one can say – *“Tinipid ng Philhealth ang budget para sa mahihirap na pasyente”*.

Not surprisingly, even government hospitals ultimately, without the increase in their budget allocation will exhaust their hospital supplies so rapidly under this PHIC program so that in the end the available and existing government hospital services will be overwhelmed by the demand for hospitalization by indigent patients. This is because there will be a rush of patients to government hospitals (e.g. DOH Regional hospitals, provincial hospitals, City hospitals, District hospitals, Hospital hospitals, etc) and it is well known that health budget allocation is not the priority of the national and local governments. Depleted of their budget, government hospitals, and ultimately if implemented in the private hospitals, will suffer a collapse of their hospital services which is beyond their control and against their wishes. Again, this only shows that this PHIC program will not be sustainable without extra budget assistance to the government (and private) hospitals. Philhealth seems to have prescribed a pill that has become the poison that will eventually kill the patient.

Again, under the PHIC scheme, there is no longer any distinction between doctors who are certified specialists and who are not. In medical practice, passing the Board or the Physician’s Licensure Examination does not certify a doctor as specialist. If a doctor desires to become a specialist, he must undergo what is called the residency or specialty training program for at least 5 years and after which he must pass the specialty Board Examinations administered by the various specialty organizations under the Philippine Medical Association (*i.e.* Philippine College of Surgeons, Philippine Obstetrics and Gynecology, Philippine Pediatrics Society, Philippine College of Physicians, Philippine Society of Anesthesiology, Philippine Academy of Family Physicians, Philippine Society of Pathologists and Philippine College of Radiology, Philippine Academy of Ophthalmology). Under these various specialties are subspecialties that require another 3-4 year fellowship training and after which he again must pass the subspecialty board examinations (cardiologists, heart surgeons, brain surgeons, oncologists, etc.). These specialty and subspecialty training and medical education is a

worldwide or global recognition and we must not in any way fall short of these global standards otherwise again we are pushed back to the era of stoneage medicine. The Philippine Medical Association is the only national association of doctors recognized by the World Medical Association which is the medical arm of the World Health Association. Unfortunately, this standard seems to have been discarded under the PHIC NBB Policy and the Care Rate Payment Scheme. Specialty Practice Guidelines will be observed more in violation than in compliance. Quality of the health service to the indigent patient is given up to give way to this PHIC program.

Again, the PMA, PHA and the PHAP stand united behind the noble endeavor of the PHIC in providing affordable healthcare to all indigent Filipinos as it is aligned with the Universal Health Coverage Program of His Excellency, President Benigno "Noy" Aquino. We must, however, see to it once this program is started it shall acquire a life of its own to maintain its sustainability and not at the expense of the quality and full health service that is deserved by the Filipino indigent. This will not be the outcome under PHIC NBB policy and Case Rate Payment Scheme for both government and private health service. *"Those who are less in life must have more in health".*

We strongly suggest the following:

1. The PHIC and PMA, PHA and PHAP must come together to do a thorough review of PHIC NBB policy and Case Rate Payment Scheme in order to strengthen its weaknesses and reinforce its strengths, if any. Meantime, we strongly suggest that its implementation be moved to a much later date, more particularly in the private hospitals, to give ample time for more intelligent discussions and to determine once and for all whether or not this is the answer to the noble objective of the Universal Health Care Coverage of the present administration;

2. The PMA, PHA and PHAP, acknowledged partners of the PHIC in health care delivery, must be separately represented in the Philhealth Board because they are the frontliners in the treatment of the Philhealth patients and thus they have first hand knowledge of the problems of the patients, their medical conditions and the patients' concerns relative to the hospital services rendered.

3. Direct and unlimited access by the indigent patient through the hospitals and doctors to the (1) Conditional Cash Transfer Program currently being carried out by the Department of Social Welfare and Development, (2) PAGCOR Funds, and (3) PCSO Funds; Lately, in a newspaper the government was quoted to have **"set P70B to save**

the poorest" (Sunday Times, Sept 11 issue, p. A-6). This P70B would be their "*salbabida*" all for the Pantawid Pamilya Program of the government under its CCT program. Lest it be forgotten, "health is wealth" and the health of the poorest may as well be the most important "*salbabida*" ever gifted by the government to the poorest;

4. Strengthen all government health facilities from the national to the local level and implement fully the Magna Carta of Public Health Workers, and establish more health centers for primary health care to prevent diseases;

5. Request the administration to increase the allocation for health from the National Budget from 2.5% to 5% of the Gross Domestic Product as prescribed by the World Health Organization with primary focus on primary health care;

It must be emphasized that these suggestions are not for the benefit and neither for the profit of the hospitals and doctors but solely to cover the cost of materials and supplies that would be employed for the treatment of the indigent patient who deserves no less than the best.



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