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Strengthening Public Financial Management Systems and Practices for Health in Response to COVID-19: A Perspective from The Philippines

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BREAKING NEW GROUND

THINKWELL

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ABBREVIATIONS

COA	Commission on Audit
DBM	Department of Budget and Management
DND	Department of National Defense
DOF	Department of Finance
DOH	Department of Health
GAA	General Appropriations Act
GPPB	Government Procurement Policy Board
GPRA	Government Procurement Reform Act
IBP	International Budget Partnership
IRM	Interim Reimbursement Mechanism
LGU	local government units
PFM	public financial management
PhilHealth	Philippines Health Insurance Corporation
PhP	Philippine peso
PPE	personal protective equipment
RA	Republic Act
RT-PCR	reverse transcriptase polymerase chain reaction
UHC	universal health care or coverage

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INTRODUCTION

The Philippines is a low-middle income country that was making significant progress in its health financing indicators before the onset of COVID-19. Before the pandemic, the country sustained average annual gross domestic product growth of 6.4% (2010-2019) and was projected to transition to an upper-middle-income country in the near term (World Bank n.d.). Current health expenditure was PhP 792.6 billion in 2019, growing by 10.9% from the previous year. Out-of-pocket expenditure as a share of current health expenditure decreased from 51.2% to 47.9% between 2015 and 2019, while government share of health spending increased from 39.1% to 42.0% (Philippine Statistical Authority 2020). Share of domestic general government health expenditure slightly increased from 6.3% to 6.6% between 2014 and 2018.

The COVID-19 pandemic posed a sudden and dramatic shock to the country's health system. The first reported case of COVID-19 in the Philippines was in January 2020, while the first local transmission of COVID-19 was confirmed on March 7, 2020. Cases started to increase, and the President issued the State of Calamity on March 16, 2020 (Office of the President of the Philippines 2020). The threat posed by COVID-19 demanded the rapid scaling of testing, isolation, and inpatient services of COVID-19 cases. Initially, only a few public hospitals were designated as COVID-19 referral hospitals and testing facilities. Eventually, COVID-19 cases were seen across all types of public and private facilities, especially during the subsequent surge in cases. Limitations brought about by the pandemic made some regulatory and administrative procedures more difficult. Increased inputs such as test kits, personal protective equipment (PPE), new medicines, and vaccines were also needed. Public and private providers demanded financing support to sustain facility operations since the lockdowns decreased cash flow for public and private providers. This decrease was due to decreased non-COVID-19 cases affecting sources such as the Philippines Health Insurance Corporation (PhilHealth) reimbursements and out-of-pocket.

The COVID-19 response demanded adjustments in health financing arrangements in the Philippines' devolved and mixed health system, and many of these adjustments were linked to the country's public financial management (PFM) system. The Local Government Code of 1991 devolved the authority and responsibility for different tiers of local government health facilities and the direct provision and management of health services, such as public health programs, as well as promotive and preventive health care. The Philippines has a robust private health sector that accounted for 53% of hospital beds in 2016 (Dayrit et al. 2018). The country also has multiple financing arrangements for allocating pooled public funds for health. The national health insurance scheme managed by PhilHealth accounts for 41.2% of public spending on health (which includes general government spending and compulsory health insurance), while the national Department of Health (DOH) and local government units (LGUs) control 38.8% and 20%, respectively. In the face of the pandemic, the government had to rapidly realign and mobilize budgetary resources, deploy them to different levels of government down to frontline providers in a coordinated fashion, and find ways to use public resources to leverage private sector actors. Hence, the COVID-19 response was, among other things, a test of PFM systems in the health sector.

This note provides an overview of key PFM barriers and enablers for driving an effective emergency response in the Philippines. It is based on a detailed desk review of government documents, as well as interviews with representatives from central and local government agencies, providers, and budget watch groups. In the sections to follow, how budgetary policies are first formulated is described, as well as how these policies have enabled a realignment of the fiscal space for COVID-19 response. Next, budget execution is explored to understand how the policies have shaped the utilization of funds. Then, in the section on budget evaluation, the implementation and monitoring of fund utilization are reviewed. Finally, lessons learned are explored for possible improvements in the PFM response in the country and globally.

BUDGET FORMULATION AND APPROVAL

The current budget development and negotiation process is a product of a series of PFM reforms over the last decade. As background, the national and local budget in the country—including health—is prepared and proposed by executive agencies at both levels and reviewed by the Department of Budget and Management (DBM) at the national level or its LGU equivalent. This is then presented for approval by their respective legislature bodies before final approval by the President or local chief executive. Program budgeting or the Performance Informed Budgeting approach was implemented in 2018 at the national level (Lakin 2018). For health, there has been improved linkage between the National Objectives for Health by the DOH and the overall Philippine Development Plan, which lays out the medium-term health goals and the country's socioeconomic agenda, respectively. At the local level, the Annual Investment Plan describes priority programs, projects, and activities that should be funded in the annual budget, and which are linked to their medium-term (three years) Local Development Investment Program (Sicat et al. 2019).

The main mechanism of the national government to finance the COVID-19 health response was through adjustments of the national budget. The DOH budget, which has been steadily increasing over the years, accounted for PhP 176 billion (or 4.3%) of the PhP 4.1 trillion national budget in 2020, which was approved on January 6, 2020 (DBM 2020a). From this, PhP 71.4 billion was allocated to PhilHealth as a premium subsidy for the poor. With the initial detection of a COVID-19 case in the country, the DOH requested a supplemental budget of PhP 2 billion as early as February 2020, but Congress delayed granting this request until local transmission was reported (Cepeda, 2020). When community cases started to increase, Congress held special sessions to ratify the Republic Act (RA) 11469 or the *Bayanihan to Heal as One Act* (*Bayanihan 1*). The law granted the President the power to exercise temporary budget measures to quickly mobilize and reallocate public funds from the 2020 General Appropriations Act (GAA) and the continuing appropriations from the 2019 GAA in response to the pandemic (Parrocha 2020). By September 2020, RA 11494 or the *Bayanihan to Recover as One Act* (*Bayanihan 2*) was legislated to augment COVID-19 response funds (Congress of the Philippines 2020a). Due to unobligated funds, both Bayanihan 1 and 2, which were only to be allocated for 2020, were extended until June 30, 2021, as per RA 11519 (Congress of the Philippines 2020c) and 11520 (Congress of the Philippines 2020d; DBM 2021a). The 2021 GAA has already recognized that recovery from COVID-19 is a priority of the government and has allocated monies to address the continuing response, especially for the procurement of COVID-19 vaccines. (DBM 2020b).

Bayanihan 1

Bayanihan 1 grants the President the authority to exercise temporary budgetary measures to mobilize public funds more quickly in response to the crisis of COVID-19. In effect, it converted a total of PhP 394.4 billion from the 2020 GAA (PhP356.7B) and the 2019 Continuing Appropriations (PhP 37.7 billion) into one big lump sum envelope from which the Executive was able to re-purpose appropriations for the COVID-19 response. This was mainly through its mandate (DOF and DBM 2020) to discontinue appropriations for at least 10% of the total unobligated allotments, and with unutilized automatic appropriations, was able to provide around PhP 266.8 billion (Congressional Policy and Budget Research Department [CPRBD] 2021a). PhP 99.4 billion continues to be tagged as unprogrammed appropriations mainly for the DOH. The rest was sourced from regular agency funds, including the National Disaster Risk Reduction and Management Fund and contingency funds.

Less than one quarter of the total Bayanihan 1 budget was allocated for health sector-related response. (DBM 2021b) Most of the allocations were to the DOH, which was tasked to procure reverse transcriptase polymerase chain reaction (RT-PCR) detection kits and hire temporary health care workers, among other things. Nonetheless, other national government agencies also received funds to cover health sector response. The Department of Interior and Local Government augmented services in LGU isolation facilities. The Department of National Defense (DND) also received funds to build additional isolation facilities. Public hospitals such as the DND's Veteran's Memorial Center and the University of the Philippines' Philippine General Hospital also received additional funding. The Department of Science and Technology was tasked to produce locally developed COVID-19 testing kits. The Department of Finance (DOF) administered a grant for cities, municipalities, and provinces to help augment their COVID-19 related activities, including health sector-related response. Of the non-health sector-related response, the majority went to social protection mechanisms for the poor and displaced workers under the Social Amelioration Program (PhP 166.4 billion).

Although the Bayanihan 1 Act directed PhilHealth to cover COVID-19 services, no additional funding was given to cover the cost of its reimbursement, even as the agency strives to expand population coverage as part of the country's approach for making progress toward the goal of universal health coverage (UHC). In early 2019, the Philippines enacted a UHC Law, RA 11223, that requires PhilHealth coverage to be expanded to all Filipino citizens. Historically, PhilHealth has collected premiums from members employed in the formal sector. It subsidizes the premiums of the remaining citizens through earmarked revenues from sin taxes (PhP 71.35 billion in 2020). Bayanihan 1 mandated PhilHealth to cover testing and treatment of COVID-19 patients and emphasized "full coverage" of medical expenses of health workers during the state of national emergency. However, PhilHealth did not receive any additional funds to cover these costs. In budget hearings conducted in the third quarter of 2020, lawmakers argued that there was not enough justification to provide additional funds for PhilHealth since they have a PhP 110 billion reserved fund aside from the decrease in payments for electives and outpatient services. Moreover, its plans for increasing premiums for direct or paying members, which the UHC Law mandated, has been deferred due to the economic hardship caused by the pandemic.

Bayanihan 1 provided additional funding support from the national government and allowed LGUs some flexibility in reallocating their own local budget for the COVID-19 response (Senate of the Philippines 2020). The additional grant managed by the DOF was given to the LGUs calculated as one-half of the one-month 2020 Internal Revenue Allotment (IRA)[1] share of the provinces and the one-month share of the cities and municipalities. The Department of Budget and Management (DBM) released Local Budget Circular No. 24 (DBM 2020c) for LGUs, which describes the mechanisms of adjusting their annual budget by setting supplemental budgets or using savings and augmentation. Additionally, the policy relaxed rules on the local disaster risk reduction and management fund so that LGUs can utilize beyond the 30% quick response fund set forth in previous policies. These additional sources of money should be reflected in the Annual Investment Plan of the LGU, with the approval of the local legislative council.

General Appropriations Act 2021

Learning from the 2020 experience, the 2021 GAA enacted last December 28, approved the PhP 4.506 trillion national budget, which considers the COVID-19 situation and its fiscal repercussions (Congress of the Philippines 2020b)**.** It was envisioned as a primary tool to "reset, rebound, and recover" by urgently addressing the pandemic, boosting infrastructure development, generating jobs, and helping communities adapt to post-pandemic life. (CPRBD 2021b) The majority of the funds continue to be for infrastructure development, or the “Build, Build” program, with an allocation of PhP 1.297 trillion, which comprises around 29% of the budget (DBM 2020d). The DOH was given a budget of PhP 203.1 billion, which is 15.5% higher than the previous year but less than 5% of the total budget. Of the total money allocated to DOH,

[1] The Internal Revenue Allotment (IRA) is a LGU’s share of revenues from the Philippine national government given as a block grant to support the funding of devolved functions. In total, 40% of national internal revenue taxes goes to the IRA. There are two steps in determining the share of the IRA for each LGU. First is determining how much of the total IRA is allocated to different levels of LGUs as follows: 23% to provinces, 23% to cities, 34% to municipalities, and 20% to *barangays*. Shares are further distributed to individual LGUs based on the following weights: 50% population, 25% land area, and 25% equal sharing (Uchimura and Suzuki 2012). To note that, on average, the IRA comprises 50% of the LGU budget while the rest are sourced through local revenue, DOH funds, PhilHealth payments, grants, and loans from donors.

PhP 71.4 billion is allocated for PhilHealth for premium subsidy of indirect members. The DOH included implementation of COVID-19 initiatives as part of its priority programs (DOH 2020a). Because of this, part of the budget allocated for DOH includes allocation for procurement of test kits, PPE, support for reference laboratories, and procurement of vaccines as part of its regular budget or sourced from loans from the Asian Development Bank and World Bank (DBM 2020e). An additional PhP61.5B was also put in as unprogrammed appropriations for the procurement of the vaccines and sourced from loans from the Asian Development Bank, Asian Infrastructure Investment Bank, and the World Bank. Only the budget related to the vaccines is currently being regularly reported by the DBM in its COVID-19 budget utilization reports. Aside from the DOH, other agencies and public institutions also continue to receive funding and are monitored for health and non-health-sector-related response, including the DND for the isolation facility and public hospitals, among others. Because of the new challenges that the country faced this year from COVID-19, such as the increased spread due to the new variants, there continues to be deliberation if a Bayanihan 3 is needed to ensure funding for the pandemic (Cervantes 2021a).

BUDGET EXECUTION

Bayanihan 1 and 2

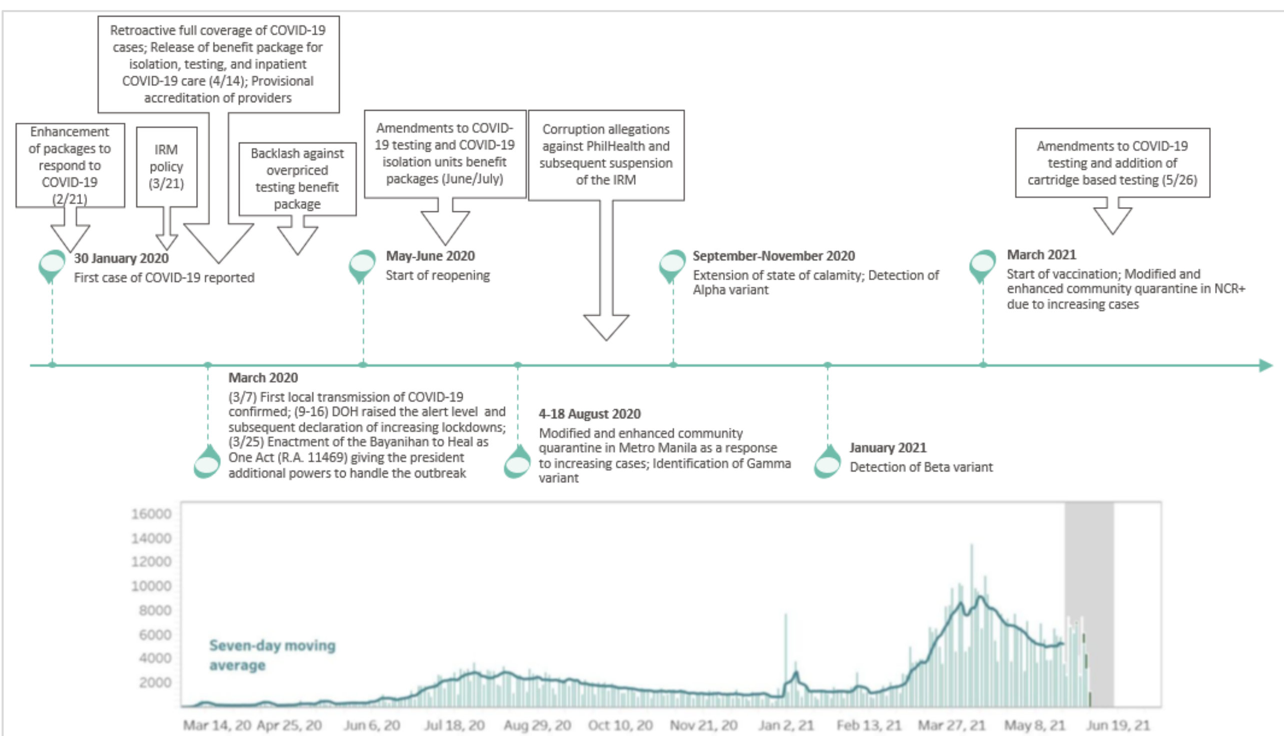
Bayanihan 1 and 2 relaxed rules related to procurement and, to a lesser extent, spending. Bayanihan 1 and Bayanihan 2 allowed exemptions on procurement provisions in the Government Procurement Reform Act for goods related to the response (such as PPE, test kits, and medicines), goods related to social amelioration measures, and construction and operations of isolation facilities. Bayanihan 2 states that information and documents related to the procurements need to be published in the Government Procurement Policy Board (GPPB) online portal and the procuring entity's website. There should be a certification that the procuring entity has exerted all efforts to secure the most advantageous price for the government. The GPPB also released resolution No. 03-2020, which specifies the guidelines on the procurement procedures during the state of emergency (GPPB 2020a). However, there was less modification of rules for spending. The DBM guidelines for LGUs state that disbursement and utilization of the additional grant and monies for COVID-19 still need to be subject to the usual local budgeting practices and pertinent provisions of the Government Procurement Reform Act and GPPB policies. However, the GPPB resolution increased the allowable amount of advance payment from 15% to 30% of the contract amount for COVID-19-related goods and services, as listed in Bayanihan 1 (GPPB 2020b). LGUs were also allowed to increase their respective personnel service cap to be able to hire more health workers. Overall, these various modifications in procurement and spending assisted public stakeholders in hastening the execution of monies from Bayanihan 1 and 2. A study looking at public procurement data shows that the typical procurement turn-around during the pandemic took nine days, although 71% of items were procured at high prices (Abante 2021).

The government also initiated various mechanisms to engage and incentivize health care workers. Initially, the DBM only released an additional COVID-19 Hazard Pay (PhP 500 per day) for government workers physically reporting to work during lockdown. The DOH implemented an emergency hiring program of temporary health personnel for select facilities with the enactment of Bayanihan 1. Incentives for these temporary workers include the basic salary plus a top-up of 20%, COVID-19 Hazard Pay, PhilHealth coverage, additional allowances, and continuing professional development units (DOH 2020b). Additionally, with the enactment of Bayanihan 2, the DOH and the DBM implemented an additional one-time Special Risk Allowance (PHP 5,000) for both public and private health care workers in direct contact with COVID-19 patients. The DOH received the additional money for these two programs and created mechanisms to suballot the funding either directly to the health facility it owns, through a memorandum of agreement with other public health facilities at the national level, or through memorandums of agreement established by its regional offices with LGUs or other health facilities. These complicated sub-allotment and payment processes may have resulted in the reported delays in payment to these workers (DOH 2020c).

PhilHealth Purchasing Adjustments for COVID-19

PhilHealth continues to develop and adjust its benefits and policies related to COVID-19 inpatient, isolation, and testing services (Figure 1). As early as February 2020, PhilHealth introduced a case rate for services related to hospital isolation of COVID-19 (PhP 14,000), while treatment for more severe disease, such as acute respiratory distress syndrome, can be charged through other benefit package rates (PhilHealth 2020a). On April 15, PhilHealth operationalized a retroactive policy ensuring full coverage via fee-for-service payment of all beneficiaries admitted due to COVID-19, from February 2 to April 14 (PhilHealth 2020b). This type of coverage continued for health care workers during the State of Emergency as a response to the mandate of Bayanihan 1 to ensure "full coverage." For other beneficiaries, new case rates were implemented for moderate, severe, and critical COVID-19 cases admitted to hospitals (PhilHealth 2020c). The accreditation process was also streamlined to ensure efficiency in contracting these facilities. For mild cases, a case rate was also developed for elderly patients admitted to hospitals, but other beneficiaries classified with mild disease will only be covered in community isolation units via a corresponding package (PhilHealth 2020d). There were also three package rates for COVID-19 testing via RT-PCR, depending on whether the testing center received donated or government-procured test kits or if other inputs were subsidized by other public funds (PhilHealth 2020e). In 2021, PhilHealth also released a new benefit package for Cartridge-based COVID-19 PCR testing (PhilHealth 2021a) (PhP 2,287) and a Home Isolation Benefit (PhilHealth 2021b).

Figure 1. Timeline of PhilHealth policies related to COVID-19



Source: Produced by authors; 7-day graph pulled from DOH 2020d

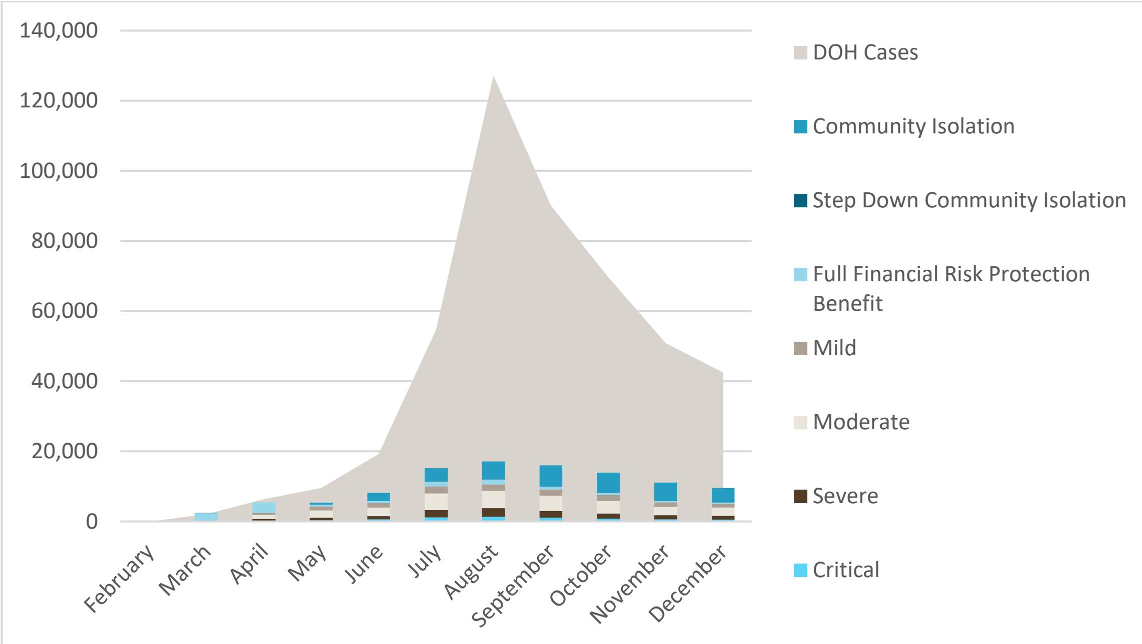
PhilHealth also modified its method to pay accredited facilities during the pandemic. The agency had an existing policy for “front-loading” funds to health care providers called the Interim Reimbursement Mechanism (IRM), whereby three months' worth of claims payments based on historical data are advanced to health facilities during natural calamities and fortuitous events to secure substantial financial aid for health facilities. PhilHealth applied this policy during the COVID-19 emergency response, advancing around PhP 15 billion worth of funds to public and private hospitals, dialysis centers, and maternity clinics (PhilHealth 2020f). The special provision for emergency situations extends the period for claims submission from 60 days to 120 days and exempts facilities from the 45 days benefit limit.[2] All valid claims during this period will be deducted from the IRM fund until fully liquidated.

In July 2020, PhilHealth came under scrutiny because of alleged anomalies surrounding the IRM. During the Senate and Congressional inquiry, concerns were raised about the IRM’s design (e.g., purpose of the fund and mechanisms for utilization, method for calculation, selection of facilities, and mechanism of monitoring, accounting, and liquidation). PhilHealth suspended the implementation of the IRM as a response to these probes (PhilHealth 2020g). Continuous delays in reimbursement that followed have resulted in a backlash from providers, especially the private sector and other stakeholders, which PhilHealth is currently trying to address (Medenilla 2021; Mercado 2021; Cervantes 2021b). In response, PhilHealth released a new payment mechanism in May 2021 called the Debit-Credit Payment Method to fast-track payments to facilities (PhilHealth 2021c). Through the Debit-Credit Payment Method, PhilHealth will immediately pay 60% of the total amount of applicable receivables, while the remaining 40% will be paid following compliance to existing claims processing requirements and procedures.

As of September 2021, PhilHealth had paid only a portion of COVID-19 claims, while a majority have been denied, returned to hospital, or are in process. In total, PhilHealth only received a total of 104,273 claims for COVID-19 isolation and inpatient-related benefits in both public and private facilities, while the DOH has documented a total number of 472,260 RT-PCR-positive cases in 2020 (**Figure 2**). Only 23% of isolation and inpatient-related benefits have been paid, while the rest were denied (18%), continue to be processed (21%), or were sent back to the hospital for additional information (38%). Similarly, of the 1,454,774 claims for COVID-19 testing-related benefits, only 40% of the COVID-19 testing benefits have been paid, while the remainder are either in process (28%) or have been returned to the hospital (23%). Many claims were returned for refiling because additional details (e.g., electronic signature, confirmatory test) were requested, which were not stated in the original policy (Talabong 2021). Uncertainties in terms of policies (e.g., payment for new medicine such as remdesivir or tocilizumab, retroactive implementation of policies) and implementation difficulties (e.g., information and communications technology issues, lack of manpower) also contribute to the delay in processing (Geducos 2021). Providers have delayed using the IRM funds due to uncertainty over the policy. As of August 2021 though, 669 of 711 (18.8%) health care facilities fully accessed their funds, and 31 (4.4%) facilities used at least 50% of their IRM funds, while 11 (1.5%) facilities liquidated below 50% of their funds (PhilHealth 2021d).

[2] Forty-Five Days Benefit Limit (45 days): A member is entitled to a maximum of 45 days confinement per calendar year. All qualified dependents of the member share another 45 days benefit per calendar year. Exceptions to this rule are members with prescribed membership validity (e.g., sponsored beneficiaries). Members belonging to this category have 45 days benefit per year of membership validity. Dependents of these members share 45 days benefit for the same period. (PhilHealth Circular No. 2020-0007).

Figure 2. Time trend of DOH cases and PhilHealth claims for COVID-19 isolation and inpatient in 2020



Source: Produced by authors based on data from PhilHealth 2021e

Vaccine Procurement

The COVID-19 Vaccination Act of 2021 simplifies spending and procurement procedures for COVID-19 vaccines (Congress of the Philippines 2021). With this, DOH and the National Task Force for COVID-19 are authorized to procure COVID-19 vaccines through a simplified process, including negotiated procurement, supply agreement, advance market commitment, advanced payment, research investment, purchase order, or any similar arrangement. Through this act, LGUs are also authorized to procure ancillary supplies and services for COVID-19 vaccine deployment through negotiated procurement and allowed to make advanced payment to providers. LGUs and the private sector that procure the vaccines need to do it as a tripartite arrangement with the DOH and the National Task Force for COVID-19.

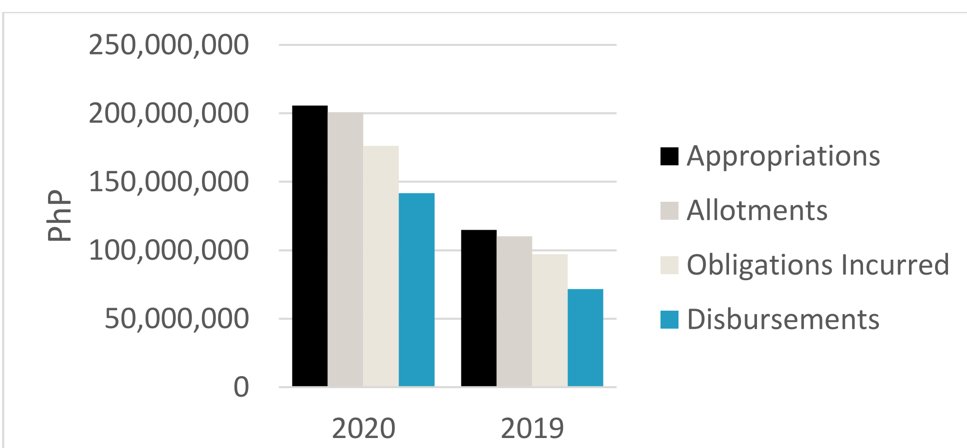
The National Vaccine Plan describes three phases for the procurement of vaccines (DOH 2021a). The first phase involves preliminary meetings with manufacturers and signing a reciprocal Non-Disclosure Agreement. During the second phase, the parties engage in formal negotiations, which normally commence with the exchange of the term sheet, which outlines all the relevant offers and details on the vaccine procurement. There will be several rounds of negotiations with the supplier for possible revisions and/or clarifications of the term sheet, which culminate in the signing by both parties of a term sheet. The national government then submits the term sheet to the financing banks for clearance, and the parties finalize and sign the supply agreement in the form of either an Advance Market Commitment, Supply Agreement, or Research & Development Investment. There are also safeguards to guarantee that government funds go to vaccines with proven safety and efficacy. The vaccine must be registered with the Philippine Food and Drug Administration through the Emergency Use Authorization before delivery and payment of balance.

BUDGET EVALUATION

There are several mechanisms by which government funds for COVID-19 are being monitored and evaluated. Bayanihan 1 requires the President to submit a weekly report on the utilization of the fund to the Joint Congressional Oversight Committee of Congress. Because of this, the International Budget Partnership (IBP) has listed the Philippines as one of the countries with an adequate level of accountability for COVID-19 funding (DBM 2021c; IBP 2021). Bayanihan 2 requires a monthly report to Congress and the Commission on Audit (COA) on targets and accomplishments of the various COVID-19 initiatives and loans and other financing details. The DBM collates the various reports on the obligations and disbursements by various agencies and LGUs. It publishes the "Status of COVID-19" releases as well in their website. They are disaggregated based on national government departments, purpose, allotments, obligations, disbursements, rate of obligation, and disbursement. There are no available reports on the actual spending by the recipient agencies. The DOF also publishes all financing secured for the COVID-19 response. While the signed contract documents are downloadable, and the page has a summary of the titles of financing agreements, effectivity date, and amounts, there is no summary of how all the contracted financing is appropriated into the government budget. Furthermore, there is no summary of the status of the use of the funds. The GPPB also requires procuring entities to upload COVID-19-related procurement contracts in its website, but an analysis of these documents revealed problems in completeness and quality of these data. The author of this analysis recommends improving data quality as well as strengthening the civic movement in monitoring this information. The 2021 GAA requires the submission by all National Government Agencies government-owned and controlled corporations, and state university and colleges (including constitutional offices) of financial and physical reports to be posted on their website and shared via the unified reporting system of the government.

The COA continues to do its yearly audit of all government agencies. In March 2021, the COA released a special report on the all-case rates, with a section on the COVID-19 case rate packages that recommended some adjustment of the rates (COA 2021a). The COA has also released its 2020 Annual Audit Report of the DOH, where some deficiencies have been reported (COA 2021b). Of the PhP 205.6 billion total appropriations, only PhP 200.9 billion was allotted, PhP 176.2 billion was obligated, and PhP 141.7 billion was disbursed (**Figure 3**). Aside from utilization and management of the fund, there were also some findings on deficiencies in procurement, lapses in handling of petty cash funds, and management of fund transfers. Fund transfers to the Procurement Service of the DBM is under public and legislative scrutiny right now because of anomalies in procurement (Burao, Lava, and Abante 2021). For the other issues, the DOH continues to address and clear these allegations (DOH 2021b).

Figure 3. Appropriations, allotment, obligation, and disbursement of the DOH in 2019 and 2020



Source: Produced by authors based on data from COA 2021b

LESSONS LEARNED

The Philippines had existing mechanisms to source and allocate funds in emergency situations, which it leveraged to address the challenges brought about by the COVID-19 pandemic. Through the flexibility afforded by the country's legal framework, massive restructuring and reallocation of the national budget was allowed so that the country was able to re-allocate around PhP 679 billion in national funds to address the unprecedented challenge of the pandemic. Additional funding available at the level of local governments as well as at PhilHealth was also leveraged for the response. Program-based budgeting, which was adopted before the pandemic, allowed the government to allocate funds to the response as the pandemic continued in 2021. As new challenges arise, the country continues to grapple with ensuring sufficient funding and prioritization of interventions related to COVID-19. Ensuring coherence in the roles of different payers—DOH, PhilHealth, and local governments—has been a challenge.

PFM adjustments to ease execution of different sources of financing were helpful in allowing for a rapid response, but further improvements are needed. Simplifying the procurement process ensured availability of inputs such as PPE and medicines, but additional steps to ensure adequate due diligence even during an emergency are warranted. Facilities have faced frequent stockouts, and there has been discussion about instituting pooled procurement mechanisms to improve efficiencies. Even before the pandemic, the DOH performed poorly in utilization and disbursement of its budget. The pandemic has cast a sharp light on these challenges and renewed calls for reforms. Aside from ensuring that execution systems are in place, however, stakeholders need to be continually educated and guided to ensure responsive processes. Local best practices and innovations in PFM also needs to be documented and shared.

PhilHealth as a purchaser can channel resources directly and rapidly to its current frontline service providers, but the pandemic has highlighted the need for refining provider payment methods as well as PFM reforms to enable facilities to receive and spend funds. PhilHealth's IRM continues to be a promising mechanism to ensure that facilities are adequately financed during an emergency, but there needs to be clarity about the intent and improved oversight over its execution, especially in the public sector, so that it can meet its goals. Better incentives need to be offered for facilities and health care workers during an emergency, and mechanisms need to be developed to ensure that they reach public and private providers quickly. PhilHealth reimbursements for public facilities controlled by LGUs flow to the LGU rather than the facilities. This can result in delays in the flow of funds to facilities and can limit the ability of facilities to source the commodities and supplies they need.

Finally, improved reporting and evaluation mechanisms need to be in place to ensure that public funds for responding to future emergencies are not misused. More detailed data about how public funds were allocated and spent for different response activities need to be made available to the public to ensure that recipient agencies have utilized their allotments as intended. Added transparency and accountability can also serve as a mechanism for continued reflection as well as civic engagement over process improvements, allowing the country to build on its successes and learn from its failures.

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