ASSESSMENT FINDINGS FOR IMPROVING THE PARTICIPATION OF FAMILY PLANNING PRIVATE SECTOR PROVIDERS IN HEALTH CARE PROVIDER NETWORKS IN THE PROVINCES OF ANTIQUE AND GUIMARAS, PHILIPPINES

MOMENTUM Private Healthcare Delivery

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Photo caption: Integrated Midwives Association of the Philippines trainer and Provincial Health Office Representative oversee a private provider insert a subdermal implant. Photo credit: Ermae Planta/MPHD Philippines. 2022.

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Table of Contents

Table of Contents **3**

Report Overview 5

Background **5**

Figure 1. Map of Western Visayas Region, Philippines 5

Figure 2. Percentage of all women aged 15-49 currently using a modern contraceptive method, 2017[3] 6

Figure 3. Sources of selected FP methods, 2017[3] 6

Assessment Objectives **6**

Methods **7**

Part 1: Desk Review 7

Part 2: Key Informant Interviews to Assess Gaps in Readiness and Willingness for Engagement in Proposed HCPNs for FP 7

Figure 4. A framework for assessing readiness and willingness of public and private sectors to establish and engage in public-private HCPNs 8

Readiness 8

Willingness 8

Table 1: Breakdown of Key Informants by Sector and Level of Operation 9

Table 2: Breakdown of Private and Public Sector Informants by Organization and Province 9

Results **10**

Desk Review 10

Table 3: Potential Enablers of Private Sector Participation in HCPNs According to Law and Regulation 10

Stakeholder Readiness and Willingness 12

Public Sector Readiness 12

Public Sector Willingness 12

Private Sector Readiness 13

Private Sector willingness 15

Key Takeaways and Considerations **17**

Table 4: Summary Findings 17

Recommendations **18**

Conclusion **19**

References **20**

Annex A: Policies and Guidelines Governing the Engagement and Contracting of Private Providers in Health Service Delivery Networks **21**

Annex B: Cross-Sectoral Gaps Identified and Recommendations for Maximizing the Value Proposition of HCPNs **1**

ABBREVIATIONS

DOH	Department of Health
FP	Family planning
FPOP	Family Planning Association of the Philippines
HCPN	Healthcare Provider Network
IMAP	Integrated Midwives Association of the Philippines
IUD	Intrauterine device
KII	Key Informant Interviews
LARC	Long-acting reversible contraceptive
LTO	License to operate
PHB	Provincial Health Board
PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PPP	Public-private partnership
RHU	Rural Health Unit
SHF	Special Health Fund
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WRA	Women of Reproductive Age

Report Overview

The Philippines has made significant progress in expanding access to family planning (FP) services in recent years, but coverage remains low by regional standards, particularly for long-acting reversible contraceptives (LARCs)[1]. Private sector FP providers are numerous, but they are underutilized because high out-of-pocket fees place these providers out of reach for many users. The Universal Health Care (UHC) Act (2019)* creates opportunities to increase access to FP services and reduce out-of-pocket fees by enrolling private sector FP providers in publicly financed healthcare provider networks (HCPNs), but operational guidance and mechanisms that private providers need to join and participate in these HCPNs are lacking at the provincial level. This technical report summarizes the results of field assessments undertaken by the MOMENTUM Private Healthcare Delivery (MOMENTUM) project in 2021, which will help improve private provider participation in FP service delivery. This report guides health sector actors in the Philippines and offers lessons learned for global audiences considering health financing mechanisms similar to HCPNs.

BACKGROUND

The Philippines has recently embarked on a process of major reform in the organization, governance, and financing of health service delivery through the passage of the national UHC Act in 2019.[2] The UHC Act seeks to re-organize the Philippines' highly devolved health system into province- or city-wide health systems, within which HCPNs can be formed. These networks are managed by provincial governments and can be composed of public, private, or a mixed set of providers. The Act also reinforces the role of PhilHealth as the primary strategic purchaser of individual-level health services, including FP. These publicly funded provincial health systems promise more efficient use of resources and the delivery of more integrated, comprehensive models of care. HCPN participation offers small, local private providers the opportunity to receive government insurance payments and access subsidized FP commodities.

FIGURE 1. MAP OF WESTERN VISAYAS REGION, PHILIPPINES

The provinces of Antique and Guimaras lie in the Western Visayas Region of the Philippines (Figure 1) and are considered 'UHC Integration Sites.' This categorization means that these provinces are committed to implementing UHC health systems reformed, including creating HCPNs. As the development of policies supporting UHC is underway, these Integration Sites offer the opportunity to test ideas and generate evidence on optimal ways to engage private sector providers within HCPNs for FP and other essential health care services.

Both provinces report a high unmet need for FP among women of reproductive age (WRA). Actual fertility (3.0 births per woman) exceeds desired fertility across Antique and Guimaras (2.7 births per woman).[3] While the use of modern contraceptives has reached the national goal in both provinces, the method mix is predominantly comprised of short-acting contraceptive methods (Figure 2).[3]

* According to the World Health Organization (WHO), UHC means that "… all people have access to the full range of quality health services they need, when and where they need them without financial hardship. It covers the full continuum of essential health services, from health promotion to prevent, treatment, rehabilitation, and palliative care across the life course." In the Philippines, the Philippine Health Insurance Corporation (PhilHealth), the national health insurance scheme, is one pathway of achieving UHC.

Private sector providers comprise 65% of health providers accredited in the Philippines through the Philippine Health Insurance Corporation (PhilHealth) system but are underrepresented in the provision of FP services, particularly LARCs.[3] Less than 20 percent of LARCs and injectable contraceptives are delivered by the private sector, despite higher rates of private sector delivery of other health services (Figure 3).[3] High out-of-pocket fees exclude many Filipinos from accessing FP services from private sector providers.[4]

In the Philippines, PhilHealth, the national health insurance scheme, is one pathway to achieving UHC. PhilHealth's benefits package covers all Filipino citizens and includes the provision of FP services free at point-of-use through public and accredited private sector service providers. However, while PhilHealth offers the potential for publicly-financed FP services in the private sector, the number of PhilHealth accredited FP private sector providers is low at less than 20 percent.[5] While private doctors and nurses working are trained and certified to have to deliver FP and LARCs, further post-qualification training is required to receive PhilHealth accreditation. Receiving accreditation has associated barriers, including time and expenses associated with post-service training and perceptions of low profitability of FP services.[4]

FIGURE 2. PERCENTAGE OF ALL WOMEN AGED 15-49 CURRENTLY USING A MODERN CONTRACEPTIVE METHOD, 2017[3]

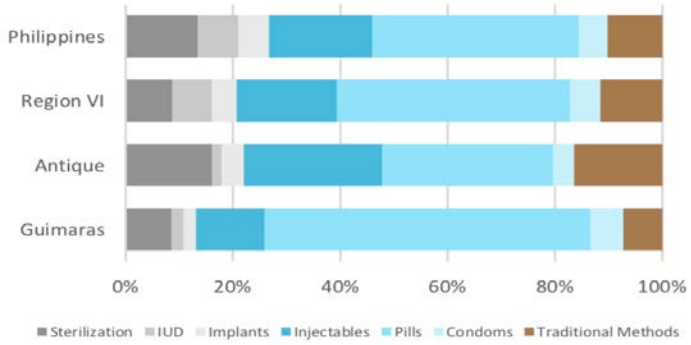
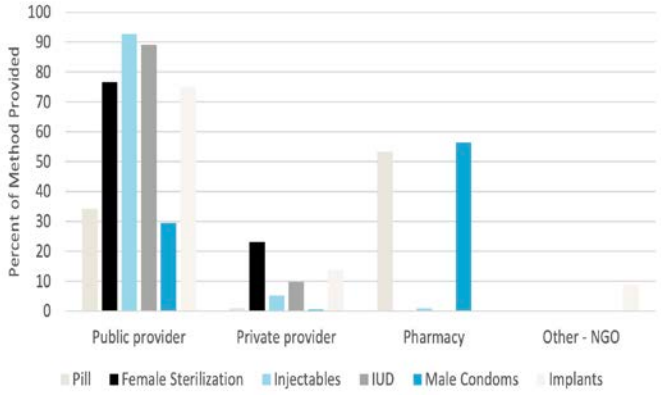


FIGURE 3. SOURCES OF SELECTED FP METHODS, 2017[3]



The establishment of HCPNs has the potential to unlock private sector capacity to expand access to FP services, but implementation has been slower than anticipated. Given the importance of expanding access to FP services within the context of UHC, MOMENTUM set out to better understand the obstacles to HCPN implementation from the perspective of public sector health leaders and private sector FP providers in both provinces.

ASSESSMENT OBJECTIVES

MOMENTUM, together with local partners in the Philippines, conducted an assessment in 2021 to inform HCPN design and implementation to improve private FP provider participation. Assessment objectives were to:

1. Describe the functions, governance, and financing of HCPNs as they relate to private sector provider.
2. Document self-reported gaps in the readiness and willingness of the **public sector** in both provinces to engage private sector providers in delivering FP services in the context of HCPNs.
3. Explore self-reported gaps in the readiness and willingness of the **private sector** in both provinces to participate in the delivery of FP services in the context of HCPNs.
4. Provide recommendations to improve private provider participation in FP service delivery in HCPNs in Antique and Guimaras.

METHODS

The assessment included two components: (i) **a desk review,** including applicable laws, regulations, administrative orders, guidelines, and policies relating to HCPNs and private sector engagement, and (ii) **key informant interviews** (KIIs) with FP service providers across the public and private sectors in both provinces.

Part 1: Desk Review

MOMENTUM conducted a desk review to understand the function, governance, and financing of HCPN as they relate to private sector engagement. We used government policy databases to identify applicable laws, regulations, administrative orders, guidelines, and policies. The final 13 policy documents for inclusion in the desk review are based on the following:

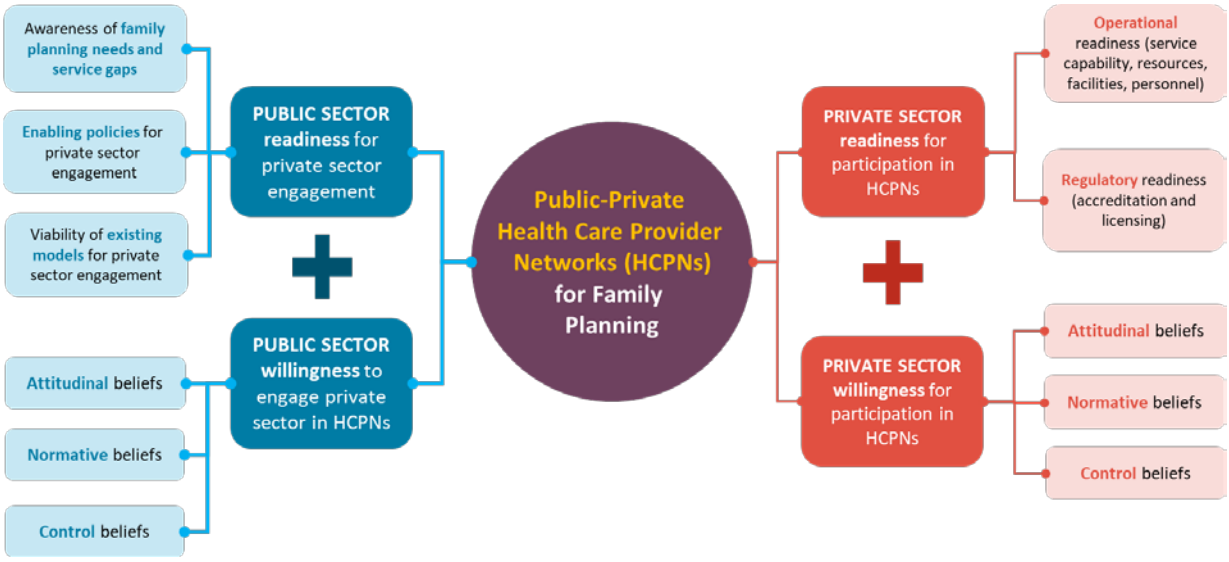
- These documents included information on private sector contracting, provider payment, and the incorporation of private providers in integrated patient referral, health information sharing, and supply chain management in an HCPN.
- Representatives of the Provincial Health Office (PHO) and Department of Health (DOH) validated the texts as including relevant content to guide the engagement and contracting of private providers in health service delivery networks.

Two local experts in health financing reviewed the thirteen documents to identify policy gaps, barriers, and opportunities to private sector engagement in HCPNs. The reviewers independently analyzed the documents and subsequently compared their notes on the identified gaps, opportunities, and insights related to private sector engagement in the networks. A full list of the documents included in the desk review and a summary of the relevant content as it relates to private sector engagement and contracting in health service delivery networks is provided in Annex A.

Part 2: Key Informant Interviews to Assess Gaps in Readiness and Willingness for Engagement in Proposed HCPNs for FP

We used KIIs to explore the readiness and willingness of (i) the public sector to engage private sector providers in HCPNs, and (ii) the private sector to be engaged in HCPNs. Figure 4 summarizes key themes generated by local public and private actors on their readiness and willingness to engage each other in the context of mixed HCPNs. As this is a scoping exercise 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.

FIGURE 4. A FRAMEWORK FOR ASSESSING READINESS AND WILLINGNESS OF PUBLIC AND PRIVATE SECTORS TO ESTABLISH AND ENGAGE IN PUBLIC-PRIVATE HCPNS



READINESS

The focus of the readiness assessments differed between the public and private sectors to account for the different roles each play in the context of HCPNs.

We assessed the readiness of the public sector in both provinces concerning its role as a future steward of HCPNs and as a potential purchaser of private sector services within the networks. Readiness was defined for the public sector as "the availability of staff, systems, knowledge, and inputs required to identify, engage, contract, and oversee private sector providers within the context of HCPNs."

We considered the readiness of private sector providers in two domains:

(i) Operational readiness, defined as "the availability of components required to provide compliant FP services including human resources, equipment, medicines, commodities, and laboratory tests."
(ii) Regulatory readiness, defined as "the ability to meet the legal, statutory, and operational requirements for compliant delivery of FP services with an HCPN."

WILLINGNESS

For the purposes of this assessment, willingness to engage, or support engagement, in HCPNs was considered a "behavioral intention" according to the Theory of Planned Behaviour[6] and included the following:

(i) **Attitudes**, in this case, toward participation in HCPNs, including perceived advantages and disadvantages.
(ii) **Subjective norms,** or the likelihood that important social referents would approve or disapprove of private sector participation in HCPNs, and an informant's motivation to comply with social referents' expectations.
(iii) **Perceived control**, in this case, over private sector participation in HCPNs.

Our heath financing experts conducted a total of 51 KIIs across public and private sectors in both provinces. KIIs included representatives operating at provincial and regional levels (Table 1). Informants were

purposively sampled based on their experience and involvement in FP service delivery. KIIs were semi-structured and conducted over video or in-person, depending on the prevailing COVID-19-related restrictions on travel and meetings. KIIs were conducted in Hiligaynon, Filipino, or English according to participant preference, and audio was recorded with participant consent. Recordings were transcribed verbatim and, where necessary, translated into English.

We conducted thematic analyses on English language transcripts of the key informants' responses to identify emerging themes and issues. Direct quotations were extracted if the study team judged them to be particularly explanatory or illustrative of the key themes identified.

TABLE 1: BREAKDOWN OF KEY INFORMANTS BY SECTOR AND LEVEL OF OPERATION

	Public Sector (n=33)		Private Sector (n=18)	
	Number of KIIs	***Select Informants***	***Number of KIIs***	***Select Informants***
Provincial Level	**24**	Managers and technical staff of the PHO, as well as managers and clinicians at public hospitals, clinics, and Rural Health Units (RHUs)	**16**	Managers and clinicians at private sector sites providing FP services, including pharmacies, clinics, and hospitals
Regional Level	**9**	Managers and directors from the regional and provincial offices of the DOH and the Commission on Population and Development	**2**	Managers from regional offices of the Family Planning Association of the Philippines (FPOP) and Integrated Midwives Association of the Philippines (IMAP)

TABLE 2: BREAKDOWN OF PRIVATE AND PUBLIC SECTOR INFORMANTS BY ORGANIZATION AND PROVINCE

Sector	Organization Type	Antique	Guimaras	Total
Private Sector (n=18)	Private hospitals	1	0	**1**
	Private birthing homes	4	3	**7**
	Private free-standing FP clinics	0	1	**1**
	Private pharmacies	2	3	**5**
	Privately practicing midwives	1	1	**2**
	Civil society and professional organizations			**2**
	Public hospitals	1	1	**2**

Public Sector (n=33)	Public lying-in clinics	2	1	**3**
	Rural health units	4	3	**7**
	Provincial health offices	6	5	**11**
	Department of Health	3	4	**7**
	Commission on population and development	1	2	**3**

RESULTS

The key results of the desk review and KIIs indicate a significant need for the private sector to address existing FP service delivery gaps and acknowledge the lack of implementing mechanisms to facilitate their potential in public-private HCPNs. The results of the desk review are presented first, followed by results from KIIs on self-reported readiness and willingness to engage or be engaged in HCPNs. Annex B provides a detailed summary of each identified gap and a corresponding recommendation for consideration in designing and implementing a public-private HCPN for FP.

Desk Review

The legal and regulatory framework underpinning HCPNs is generally favorable toward private sector participation. Section 19 of the UHC Act explicitly encourages the involvement of private sector providers in HCPNs. The associated implementing rules and regulations and administrative orders provide a high flexibility index in how private sector providers may be engaged and contracted. If fully operationalized, the UHC Act and associated regulations offer several potential improvements to the "status quo" of health financing and governance of private sector providers, as outlined in Table 3.

TABLE 3: POTENTIAL ENABLERS OF PRIVATE SECTOR PARTICIPATION IN HCPNS ACCORDING TO LAW AND REGULATION

Opportunity	Current state	Future state as envisaged in law and regulation	Benefit to private sector providers
A shift from individual provider-level to network-level contracting by PhilHealth	PhilHealth contracts with private sector providers directly. The providers must submit claims directly to PhilHealth, with reimbursements made directly from PhilHealth to providers.	The UHC Act mandates a shift to network-level contracting, where PhilHealth contracts and pays HCPNs as juridical entities rather than engaging with individual providers.	Network-level contracting can reduce the cost and time burden of contract management, claims submission, and other administrative processes for those private sector providers operating within HCPNs.
A shift from reimbursement	PhilHealth provides payment through reimbursement only with	The UHC Act commits PhilHealth to shift to pre-payment of	Pre-payment could significantly reduce the incidence and impact of delayed reimbursements to those

Opportunity	Current state	Future state as envisaged in law and regulation	Benefit to private sector providers
to pre-payment of providers	a lengthy and administratively complex claims procedure.	providers, with payments made in advance of service provision.	private sector providers participating in HCPNs.
Pooling of resources in a provincial-level Special Health Fund (SHF)	Funding for FP services flows to the local level from various sources, with responsibility for allocation decisions spread across multiple actors operating at the provincial, regional, and national levels.	The SHF consolidates and streamlines sources of funding for individual health services, including FP, and confers Provincial Health Boards (PHBs) a high degree of autonomy in how they budget and allocate health resources.	Consolidating funding and allocation authority at the provincial level will make it easier for PHBs to allocate resources to private sector providers.

Although the regulatory and legal environment is generally supportive of private sector participation in HCPNs, the desk review revealed a need for practical operational guidance on how private sector providers ought to be optimally engaged in HCPNs. PhilHealth is mandated under the UHC Act to provide operational guidance on pre-payment mechanisms for service providers. The national DOH is mandated to establish operational policies for establishing and managing HCPNs. At the time of assessment, however, these national guidelines were still forthcoming. Content analysis of the included policies, supported by expert interviews with national health authorities and representatives from professional organizations (n=8), identified the following policy gaps:

- Non-existent guidelines on how provincial governments may legally contract private providers into public-private HCPNs.
- Institutional arrangements around co-ownership and shared management between public and private parties still need to be made.
- FGD with Private Providers raised inquiries about how the service catchment population will be defined and whether they may still cater to private patients outside their designated catchment area.
- Guidelines for integrating private FP providers in learning needs assessment, training delivery, monitoring, and evaluation are still pending.
- No guidelines for integrated, collaborative forecasting, procurement, storage, and distribution of commodities within HCPNs.
- Specific PhilHealth guidelines on the costing of payments and the processing and disbursement of prospective payments are still pending.

Stakeholder Readiness and Willingness

PUBLIC SECTOR READINESS

On assessment, key informants across the public sector in both provinces reported several cross-cutting challenges in their perceived readiness to engage and contract private sector providers in the context of HCPNs.

MANAGERIAL CAPACITY REQUIRED TO ESTABLISH AND SUPPORT PRIVATE SECTOR PARTICIPATION IN HCPNS

The majority of the provincial (89%) and regional (67%) public health authorities raised concerns that the demands of oversight and management of HCPNs and their private sector participants may exceed the bandwidth of the managerial workforce at current staffing levels. One respondent indicated that new positions would be required to handle the administrative and managerial burden of HCPNs and raised concerns about how these would be funded. Respondents' concerns about insufficient workforce resources were compounded by a perceived increase in the workload of existing managerial staff, which was unanticipated when the UHC Act was brought into law. Commonly reported were additional demands on staff time related to ensuring the continuity of essential services in the context of the COVID-19 pandemic; scaling and routinizing the COVID-19 immunization program; and addressing the backlog of cases caused by disruption to service delivery and care-seeking in the earlier stages of the pandemic.

> *"For us to implement the UHC law, it will mean that the absorptive capacity of the Provincial Health Office will be expanded by 10-fold or more--and that will mean staffing the PHO by even more than the entire provincial government combined. Even more if we have to manage private providers as well. We cannot afford that."*
>
> **Provincial health official, Guimaras Province**

LACK OF PROVINCIAL-LEVEL GUIDELINES, POLICIES, AND REGULATIONS WHICH CONTEXTUALIZE THE PROVISIONS OF THE UHC ACT FOR THE LOCAL PRIVATE SECTOR

Nearly all (91%) of the public sector respondents were generally aware that the UHC Act supported the participation of private sector providers within HCPNs, but most provincial respondents (78%) reported the lack of practical guidance to help them operationalize such participation within their provinces. One respondent stated the following:

> *"I know the law does mention that private providers may be contracted into public-private HCPNs for integrated service delivery. But how exactly do you do that?"*
>
> **Provincial health official, Antique Province**

The majority (61%) of provincial officials expressed willingness to develop their own provincial-level guidelines for engaging private providers in HCPNs, but more than half (56%) also felt unempowered to do so in the absence of national-level guidance:

> *"They [DOH and PhilHealth] should provide us more specific and implementable guidelines as well as templates which we can adapt."*
>
> **Provincial health official, Antique Province**

PUBLIC SECTOR WILLINGNESS

In interviews, key informants across both provinces reported several perceived or anticipated barriers to pursuing private sector participation in HCPNs.

MISALIGNMENT OF VALUES AND INCENTIVES BETWEEN THE PUBLIC AND PRIVATE SECTOR PARTICIPANTS IN HCPNS

Nearly half of the public service providers (42%) questioned the suitability of private sector providers in HCPN participation and raised concerns about how the private sector's need for profitability might be reconciled with the public sector's priorities of improving health equity and health outcomes. One respondent noted the following:

> *"The way we do things is different here [in the public sector] and I can already anticipate that they [private providers] may not be able to align and comply […]"*
>
> **Municipal Health Officer, Antique Province**

A few service providers in the public sector (25%) were concerned that private sector providers' pursuit of profit may lead to adverse service outcomes for clients, for instance, by reducing costs through 'cutting corners' or increasing revenue by subjecting clients to unnecessary procedures.

FRAMING OF PRIVATE SECTOR PROVIDERS AS COMPETITORS

More than a quarter (42%) of public sector providers explicitly framed private sector providers as competitors and questioned their role and function in collaborative initiatives like HCPNs. The competition was often framed concerning the availability of public financing, whereby allocating resources to a private sector provider could risk depriving public sector providers of funding. The prevailing sentiment among a majority of public sector informants was to utilize limited public resources to address public service delivery gaps first, and if additional resources come in, the idea of engaging the private sector may be entertained.

> *"If we engage them in the HCPNs, then I can already say that most of our patients will go to them instead, especially if they will also provide the services for free or at a much lower price. While that will help [unburden us], I hope it's not too much because we might end up not being able to reimburse anything [from PhilHealth]."*
>
> **Public midwife, Antique Province**

PERCEIVED LIMITED VALUE OF PRIVATE SECTOR PROVIDERS TO CONTRIBUTE TO FP

More than half of provincial public sector respondents (56%) expressed doubt about the value of private sector providers for the provision of FP services in their province. In some instances, this was because PhilHealth-accredited private sector providers were not available in their area:

> *"For the entire province, I can only name one or two private providers that can insert (and remove) subdermal implants."*
>
> **Provincial health official, Guimaras Province**

In other cases, public sector providers felt the incremental value of private sector participation could have been improved in certain aspects of FP service delivery because the public sector could either provide these services or deliver them with further investment.

PRIVATE SECTOR READINESS

In interviews, KII respondents from the private sector discussed various challenges in their readiness to deliver FP services. Regarding operational readiness, the two most frequently anticipated gaps were (i) the availability of appropriately trained staff and (ii) challenges in procuring essential commodities. Regarding regulatory readiness, the providers repeatedly reported challenges in (i) acquiring and maintaining the necessary license to operate their facility and (ii) meeting standards for and securing PhilHealth accreditation.

SHORTAGE OF STAFF WITH THE REQUISITE TECHNICAL SKILLS

The majority (64%) of private sector providers reported gaps in staff availability with the specific technical skills required to undertake priority FP services. FP is a spectrum of services of varying technical complexity, from the distribution of condoms to minor surgical procedures like the insertion of implants and major

surgical procedures like tubal ligation. Some elements of FP service delivery require in-service technical training. For instance, though midwives can be accredited for the insertion and removal of implants and intrauterine devices (IUDs), the clinical skills required for these procedures still need to be included in pre-service training curricula for midwives.

In contrast to the public sector, for whom training is provided free of charge, private sector providers must absorb the required costs of the additional training. Training costs can be prohibitive, including the direct costs of training provision and the indirect costs of travel and attendance at courses, which are often held out-of-province. One respondent said the following:

> *"Most of the training is located in [the nearest City]. I don't think they've ever offered this training here, for us private providers. So, if I wanted to avail the training, I will have to suspend my operations for up to a week, and to spend additional on transportation, food, and accommodation."*
>
> **Clinic manager, Guimaras Province**

SHORTAGE OF ESSENTIAL FP COMMODITIES, PARTICULARLY THOSE FOR LARCS

Nearly all (94%) informants reported long-standing challenges in securing reliable supplies of essential FP commodities, particularly those for implants and IUDs. Common reasons cited for supply challenges included a lack of suppliers in the local market, high commodity prices, and frequent supplier stockouts.

About a quarter (27%) of respondents reported satisfaction with the supply and pricing of FP commodities under a previous short-lived, Government-led procurement initiative:

> *"There was a time in 2018 when the province would send to us free commodities especially IUDs and implants because their RHUs cannot provide these. Of course, that was good for us because they were free, and we did not have to buy it ourselves. And we got to provide these services to more women at significantly lower rates. But that only lasted for just a little over a year."*
>
> **Private midwife, Antique Province**

CHALLENGES IN ACQUIRING AND MAINTAINING A DOH LICENSE TO OPERATE

All healthcare facilities in the private sector require a license to operate (LTO) issued by the DOH. The application process for an LTO is perceived as arduous and expensive, with providers required to secure business and tax permits from local and national government departments and demonstrate compliance with various standards, including infrastructure, equipment, staffing, and waste management.[5] Annual renewal fees cost between US$10-$60, depending on the type of facility, though the ongoing investment required to ensure compliance can be much higher.

Nearly all (94%) private providers in the two provinces reported challenges in meeting often obscure baseline requirements for an LTO and a lack of familiarity with the process for renewal. More than half of the respondents (58%) noted the high financial costs and time investment required to secure renewal:

> *"We need to renew our LTO every 1-3 years and doing so can be physically and financially taxing. So, I understand why the other birthing homes do not want to get accredited."*
>
> **Clinic manager, Antique Province**

CHALLENGES IN ACCREDITATION TO PHILHEALTH

PhilHealth accreditation requires the frontline staff of private sector providers to undergo DOH-certified training courses and post-training evaluations. The specific training and post-training assessment required for accreditation vary according to the service in question and by health worker cadre. Training costs can be prohibitive and are borne by the private sector provider without subsidy.

More than half of private sector respondents (52%) frequently reported concerns about the high cost of training for PhilHealth accreditation:

> *"For you to get PhilHealth accredited, you need an LTO and the certification of FP training. Attending the entire training set for FP alone can cost you up to ten thousand [Philippine peso][†] for training fees alone."*
>
> **Clinic manager, Guimaras Province**

PRIVATE SECTOR WILLINGNESS

Informant interviews revealed several cross-cutting barriers to private sector willingness to participate in HCPNs. Barriers were often based on providers' previous experiences engaging with PhilHealth and provincial health authorities.

ANTICIPATED CHALLENGES WITH PAYMENT

Nearly all private sector providers (97%) anticipated challenges in being paid for the delivery of FP services, reflective of the current delays to reimbursement experienced when delivering other PhilHealth-reimbursed services. Most respondents (91%) reported challenges in payment reliability, with many reporting adverse consequences on business operations and finances.

> *"What gets me frustrated is that the payments are irregular and unpredictable. Sometimes you get paid after a month, sometimes after two months, sometimes it takes three to six months before the reimbursement comes to you. It is hard to plan well your expenditures and purchases ahead when you don't know when the money will come in."*
>
> **Clinic manager, Antique Province**

Anticipated delays in payment were one of the most frequently cited reasons for the lack of willingness to engage in HCPNs, with many responses reflecting the following:

> *"If the government doesn't pay us on time like what it does right now, then I don't think I would be very open to being engaged in the HCPN."*
>
> **Clinic manager, Guimaras Province**

COMPLEX CLAIMS PROCEDURES WITH HIGH RATES OF REJECTION

All private sector respondents anticipated challenges in making claims for FP services because of previous negative experiences navigating the claims system at PhilHealth. Commonly reported issues included the requirement to submit claims online, which is difficult with unreliable internet connectivity; limited information from PhilHealth on how to manage claims; and little or delayed communication by PhilHealth on processing claims made. More than half of providers (52%) raised concerns that these complexities could lead to additional costs:

> *"We tried the e-claims system ourselves and it really didn't make it easier for us to submit and process our claims. If anything, this is additional cost to us since we have to hire encoders to enter the data into the system."*
>
> **Clinic manager, Antique Province**

LIMITED GUIDANCE ON THE CONTRACTING MECHANISMS TO BE USED

Some respondents (36%) recognized that the level of reimbursement, risk, and autonomy afforded to private sector partners in HCPNs would vary significantly according to the contractual mechanism used to facilitate their engagement. One respondent noted the following:

[†] Approximately US$180.

"For all we know, we might get the losing end if the agreements are not clear."

Clinic owner, Guimaras Province

For many providers, lack of clarity in contracting arrangements disincentivized participating in HCPNs.

"It all seems very abstract to me and I'm not sure whether I can really commit to signing any contact with the public sector until all the details have been ironed out."

Private pharmacy owner, Guimaras Province

LOW-COST RECOVERY RATE AND LIMITED PROFITABILITY FOR SERVICES DELIVERED WITHIN THE HCPN CONTEXT

Almost all of the providers (97%) interviewed raised concerns about PhilHealth reimbursement rates for FP services which were broadly viewed as uncompetitive considering the high costs to be recovered for essential inputs like FP commodities, staff training, and accreditation. Further, nearly half of the providers expressed doubts about the incremental added value of participation in an HCPN compared to their standard business practices:

"Even now that I am not PhilHealth accredited, I am already earning a profit and I still get to see patients. I am not certain whether there is any additional value to me if I will join the HCPN."

Clinic manager, Antique Province

ADMINISTRATIVE AND PROCEDURAL BURDEN OF PARTICIPATION IN HCPNS

Nearly half of the respondents (45%) raised concerns about the anticipated administrative and procedural burden of HCPN membership, including those related to registration and due diligence and those about longer-term processes like performance management, information sharing, and contract renewal.

As the public purchaser of health services, many of the administrative and operational processes required for compliant HCPN operations will cascade from PhilHealth's oversight function for service quality, health care information management, and financial management. The UHC Act mandates PhilHealth to provide operational guidance to PHBs for these processes, but as mentioned, this guidance is still under development.

CONCERNS AROUND THE PUBLIC SECTOR'S WILLINGNESS TO ENGAGE WITH THE PRIVATE SECTOR ON FAIR AND EQUITABLE TERMS

A significant number of private sector providers (39%) anticipated concerns about whether they would receive fair and equitable treatment in the context of HCPNs led and managed by the public sector.

"I think they [public providers] see us [private providers] as competitors, and maybe they are the ones maybe less willing to work with us."

Pharmacy manager, Guimaras Province

Most respondents (79%) reported a need for more visibility into policies and decision-making processes, particularly on budget and resource allocation.

"If I join the HCPN, does it mean that the government will have some sort of 'control' over my operations? Will I get audited like all other government offices? What can or can I not do? I am unclear about the arrangements, especially over decision-making."

Clinic manager, Guimaras Province

LIMITED KNOWLEDGE OF HCPNS AND THE PRIVATE SECTOR ROLE WITHIN THEM

Nearly all respondents (88%) reported little knowledge and awareness of the purpose, function, structure, and operation of HCPNs in general, compounded for many respondents by a need for more understanding of the proposed level and mechanism of private sector engagement.

> *"Honestly, before this interview I had no idea what an HCPN is […]"*
>
> **Pharmacy owner, Guimaras Province**

KEY TAKEAWAYS AND CONSIDERATIONS

The assessment highlights challenges that public and private sector providers face in the Philippines and documents information related to readiness and willingness to engage with HCPNs. The analysis identifies cross-cutting challenges in the public sector, including the managerial capacity required to establish and support private sector participation in mixed HCPNs and the need for provincial-level guidelines, policies, and regulations that contextualize the UHC Act for the local private sector. In contrast, the private sector faces challenges such as staff shortages with the requisite technical skills and essential FP commodities, acquiring and maintaining the DOH license, and PhilHealth accreditation. Table 4 presents summary findings.

Table 4: Summary Findings

Readiness	
Public Sector	**Private Sector**
• **Managerial capacity required to establish and support private sector participation in HCPNs.** • **Lack of provincial-level guidelines, policies, and regulations which contextualize the provisions of the UHC Act for the local private sector.**	• Trained private FP providers who can secure licensing and accreditation are limited. Private providers need support to complete specialized training at their own cost to apply for PhilHealth accreditation to offer FP services. • Private providers encounter significant challenges in accessing some FP commodities, particularly contraceptive implants, due to tremendous variability in market prices and the limited availability of local suppliers. • Due to complex and costly requirements, many private providers hesitate or resist securing DOH licenses and PhilHealth accreditation.
Willingness	
Public Sector	**Private Sector**
• **Public sector stakeholders express hesitancy about whether the private sector has similar values to the public sector and if public engagement will local public health system goals will align with their commercial interests.** • **The public sector may see private providers as competitors, especially concerning**	• Providers anticipate challenges with payment and complex claims procedures with high rates of rejection. • Limited guidance exists regarding how private providers may be legally contracted into HPCNs and the administrative and procedural burden of participation in HCPNs.

availability and allocation of public financing.	• There are concerns about low-cost recovery rates and limited profitability for services delivered within the HCPN context • Providers have concerns around the public sector's willingness to engage with the private sector on fair and equitable terms. • Private providers have limited knowledge of HCPNs and the private sector role within them.

The findings suggest that values and incentives across public and private sectors need to align with one another, which is a significant barrier to maximizing the participation of private providers of FP in HCPNs. In addition, the perceived competition between public and private sector providers in the allocation of public financing, lack of familiarity with HCPN process, perceived high costs of compliance, and accreditation requirements are significant challenges in the willingness of private sector providers to engage with HCPNs.

Overall, the assessment highlights the complexities and challenges that must be addressed to ensure successful private sector engagement in HCPNs, as well as for global audiences considering similar health financing mechanisms. Addressing these challenges requires a multi-sectorial stakeholder approach that involves support for developing provincial-level guidance, addressing the capacity gaps in both sectors, and increasing the availability of essential commodities and training for the private sector. Additionally, aligning values and incentives and building trust between the public and private sectors should be prioritized to promote successful engagement in mixed HCPNs.

RECOMMENDATIONS

To address the cross-cutting gaps identified in this assessment and maximize the value proposition of HCPNs for private sector engagement, MOMENTUM recommends the following immediate, short-term, and longer-term actions. Additional recommendations for each identified gap are further detailed in Annex B for consideration in designing and implementing HCPNs for FP and other similar public-private engagement models.

In both the short and long-term, intermediaries can assist in overcoming the challenges that hinder private providers from fully engaging and collaborating with the public sector to provide FP services, thus increasing the value of their participation. Intermediaries act as facilitators, forming a connection between individual providers, governments, patients, and suppliers so that they can collectively carry out health system functions that would be difficult to manage independently.[7] These entities can impartially assess the value proposition offered to private providers and facilitate conveyable solutions to offset challenges for both sectors. Intermediaries will play a critical role in advocating for the interests of private sector providers, addressing their distrust of the public sector, bridging gaps in provider skills related to managing claims administration systems, and reducing the burden of licensing, accreditation, and administrative tasks, among other factors.

To address private sector concerns about equity of resource allocation in HCPNs and leverage their expertise, private sector engagement in governance and financing should increase. An intermediary organization such as IMAP or FPOP can represent private sector providers, offer DOH-compliant clinical training, and advocate for private sector-friendly practices. IMAP is widely acknowledged as a successful proponent of private sector-friendly policies with the DOH and PhilHealth, with nationwide membership encompassing both public and private providers through its 153 chapters. The organization is highly regarded

for its robust connections and social capital with stakeholders at all levels of the health system, including public and private entities. Provincial health authorities should establish formal representation for the private sector on decision-making bodies related to HCPNs over time, such as the PHB and finance committees responsible for annual operational and local investment plans for health.

In the short to medium term, provincial health officials should work with private sector providers to co-develop clear policies and guidelines for implementing HCPNs in their province. The development of clear policies and guidance for HCPNs will help overcome perceived misalignment between the public and private sectors by making participation terms, benefits, and risks clear to both parties. Policies should address key private sector concerns, for instance, by including commitments on the turnaround time from claim to reimbursement. Policies should also maximize the value proposition for public and private sector stakeholders, including model contracts that present the terms and conditions of each contracting method.

In the longer term, provincial health officials should prepare to take full advantage of the fiscal autonomy envisaged in law for the provincial SHF to ensure that private sector participants in HCPNs have reliable and equitable access to essential inputs like commodities and training. The specific implementation mechanisms available to PHBs regarding the SHF will depend on the particular guidance laid down by the various responsible government agencies. At a minimum, PHBs should prepare to establish private sector-specific modules within the budgeting and procurement activities linked to the SHF for their province, including those activities like commodity quantification, demand forecasting, annual budgeting, and medium-term expenditure planning. Over the longer term, PHBs may create province-wide prime vendor agreements with pre-qualified FP commodity wholesalers or work to pool procurement for essential inputs for the HCPNs within their province.

CONCLUSION

This analysis confirms that there are several challenges that affect the private sector's ability and willingness to participate in HCPNs for FP. This creates an opportunity to develop the necessary guidance and mechanisms to make HCPNs more appealing to private sector providers. To achieve this, MOMENTUM will work with private sector partners (including IMAP and FPOP), the local governments of Antique and Guimaras, the DOH, and PhilHealth to effectively implement the mechanisms identified in this assessment, thereby increasing the participation of private sector FP providers. The findings from this assessment will be utilized by MOMENTUM to raise awareness, build capacity, and enhance the operational readiness of private providers to deliver quality FP services in such a network. The knowledge gained from this work will not only ensure sustainable engagement of private sector providers in publicly financed HCPNs in Antique and Guimaras but will also serve as a vital reference for establishing HCPNs in other UHC Integration Sites.

In comparison to other low- and middle-income countries, the Philippines has a relatively advanced national insurance program that effectively utilizes the strengths of the private sector within a mixed health system. However, MOMENTUM's analysis highlights that establishing the foundational framework for public-private engagement does not guarantee the willingness and preparedness of both sectors to participate in such initiatives. Therefore, there is a current need for guidance to facilitate the implementation of HCPNs to ensure that the value proposition of HCPNs is fully realized, which can motivate and sustain private FP provider engagement. MOMENTUM will work with the public and private sector partners and stakeholders to manage the operationalization of HCPNs collaboratively and to build the capacity of local organizations to foster continued collaboration. The lessons learned from this effort will not only benefit the establishment of HCPNs in Antique and Guimaras in the short term but also provide valuable experience for other countries looking to create similar public-private engagement models in line with their future UHC commitments.

REFERENCES

1. FP2020. Commitment to Action: Measurement Annex [Internet]. 2015. Available from: http://2014-2015progress.familyplanning2020.org/uploads/15/03/FP2020_MeasurementAnnex_2015_Spreads.pdf

2. Republic Act No. 11223 An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor [Internet]. 2019. Available from: https://lawphil.net/statutes/repacts/ra2019/ra_11223_2019.html

3. Philippine Statistics Authority (PSA) and ICF. Philippines National Demographic and Health Survey 2017 [Internet]. Quezon City, Philippines; 2018. Available from: https://dhsprogram.com/publications/publication-fr347-dhs-final-reports.cfm

4. Apostol G., Boxshall M., Sheahan K., Apostol V. Leveraging private sector primary care providers to increase access to family planning in the Philippines. [Internet]. Washington, D.C.: ThinkWell; 2019. Available from: https://thinkwell.global/wp-content/uploads/2019/11/19-09-27-Phil-FP-private-sector-report_Final.pdf

5. Yason-Remonte, M.A. 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.; 2018; Manilla, Philippines.

6. Ajzen I. The theory of planned behavior. Organizational Behavior and Human Decision Processes. 1991 Dec;50(2):179–211.

7. Bolender T, Lagomarsino G, Dimovska D, Soyinka O, Aiyenigba E, Arias J. Intermediaries: The Missing Link in Improving Mixed Market Health Systems? Results for Development; 2016.

ANNEX A: POLICIES AND GUIDELINES GOVERNING THE ENGAGEMENT AND CONTRACTING OF PRIVATE PROVIDERS IN HEALTH SERVICE DELIVERY NETWORKS

Year	Policy/guideline included in the desk review	Description
1991	**Republic Act No. 7160: Local Government Code** *An Act Providing for a Local Government Code of 1991*	Mandated responsibility and autonomy to manage local health facilities and services to different levels of local government units.
1991	**DOH Rules and Regulations Implementing the Local Government Code of 1991**	Guided the reorganization of the DOH and devolution of health functions to local government units.
2017	**Administrative Order No.2017-014:** *Service Delivery Networks*	Outlines guidance on the formation of service delivery networks and public-private partnerships.
2018	**Administrative Order No. 2008-0014** *Strategic Framework and Implementing Guidelines for FOURmula One Plus (F1 Plus) for Health*	Health system reforms framework of the DOH for 2017 to 2022.
2019	**Republic Act No. No. 11223: Universal Health Care Act** *An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System and Appropriating Funds Therefore*	Provided key reforms to achieve UHC in the country, including via the formation of HCPNS.
2019	**Republic Act No. 11223** *Implementing Rules and Regulations of the Universal Health Care Act*	Implementing rules and regulations of the Universal Health Care Act (Republic Act No. 11223).
2019	**Administrative Order No. 2021-032:** *Implementation of the Philippine Health Development Plan*	Set an implementation plan for the Philippine Health Development Plan, a macro plan for health infrastructure and equipment supporting the Universal Health Care Act (Republic Act No. 11223).
2019	*Supplemental Guidelines for the Implementation of Public-Private Partnership for the People Initiative for Local Governments*	Guided local government units on public-private partnership modalities and implementation.
2020	**Administrative Order No. 2020-021** *Guidelines on Integration of the Local Health Systems into Province-Wide and City-Wide Health Systems*	Provided guidance on general procedures and mechanisms by which local government units can integrate health systems into HCPNs.
2020	**Administrative Order No. 2020-0019** *Guidelines on the Service Delivery Design of Health Care Provider Networks*	Set service delivery and referral standards of HCPNs.
2021	**Joint Memorandum Circular 2021-0001** *Guidelines on the Allocation, Utilization, and*	Provided guidance for PHB on the allocation, consolidation, and monitoring of SHF.

Year	Policy/guideline included in the desk review	Description
	Monitoring of, and Accountability for the Special Health Fund	
2022	**Republic Act No. 6957 (as amended by Republic Act No. 7718).** *An Act Authorizing the Financing, Construction, Operation and Maintenance of Infrastructure Projects by the Private Sector and for Other Purposes*	Provided contracting and non-contracting options for private sector engagement in health.
2022	**Revised Implementing Rules and Regulations of R.A. No. 6957,** *"An Act Authorizing the Financing, Construction, Operation and Maintenance of Infrastructure Projects by the Private Sector and for Other Purposes", As Amended by R.A. No. 7718.*	Provided contracting and non-contracting options for private sector engagement in health.

ANNEX B: CROSS-SECTORAL GAPS IDENTIFIED AND RECOMMENDATIONS FOR MAXIMIZING THE VALUE PROPOSITION OF HCPNS

Sector	Area	Gaps Identified	Notes	Recommendation
Public Sector	*Readiness*	Managerial capacity required to establish and support private sector participation in HCPNs	There is a need for more practical guidance on how the public sector can manage public-private HCPN operations for FP. Many provincial health offices, especially those in remote provinces, lack experience in public-private partnerships and require direction on how and where to engage the private sector.	Although not health-specific, local public sector stakeholders could begin by reviewing national guidelines for managing private sector engagement and establishing public-private partnerships, which could be applicable to public-private HCPNs. From the national level, the public-private partnership (PPP) unit of the Department of Health and the PPP Center of the Philippines could assist provincial governments in establishing regulations for HCPNs and continuous support to build the managerial capacity for maintaining the networks. Further, to ensure sustainable operations, guidelines for HCPNs should be co-designed with representation from the private sector.
		Lack of provincial-level guidelines, policies, and regulations which contextualize the provisions of the UHC Act for the local private sector	Both provinces are developing their local guidelines for establishing and managing HCPNs, despite an absence of national-level guidance.	
	Willingness	Misalignment of values and incentives between the public and private sector participants in HCPNs	Public sector stakeholders express hesitancy about whether the private sector has the same values as the public sector and if engaging them can balance their bottom lines with local health system goals.	Public sector stakeholders must be oriented and inculcated with greater awareness, understanding, and appreciation of engaging the private sector in achieving UHC goals and health outcomes. Public sector stakeholders can establish routine opportunities for solidarity-building where both sectors gain a common understanding of the gaps between demand and service delivery, and mutual interests and benefits are identified. To promote a culture of collaboration, one opportunity is to ensure representation of the
		Framing of private sector providers as competitors	The public sector may see private providers as 'competitors, mainly concerning the availability and allocation of public financing.	
		Perceived limited value of private sector providers to contribute to FP	The idea of private sector engagement is more complementary than a strategic partnership; the private sector is a 'filler of	

Sector	Area	Gaps Identified	Notes	Recommendation
			gaps' rather than a 'co-creator' and 'co-steward.'	private sector in provincial health boards, as outlined in the UHC Act. The provincial health board could issue a directive stating that the private sector is needed for FP service delivery, particularly in underserved areas, so their engagement is seen as complementary rather than competitive.
Private Sector	*Readiness*	Shortage of staff with the requisite technical skills	There is a limited number of trained private FP providers in the provinces who are able secure licensing and accreditation. Moreover, private providers need help to complete specialized training at their own cost to apply for PhilHealth accreditation to offer FP services.	If they intend to engage the private sector, the public sector should provide training support to private providers to obtain the requisite licenses and accreditations. Currently, the DOH offers this training for free to public providers, and this training could be extended to the private sector, either for free or at a discounted rate. A more long-term recommendation is for public and private sector stakeholders to identify new opportunities for these specialized trainings to be incorporated into in-service training. This training should satisfy specialized FP training requirements of purchasing programs.
		Shortage of essential FP commodities, particularly those for LARCs	Private providers encounter significant challenges in accessing some FP commodities, particularly contraceptive implants, due to tremendous variability in market prices and the limited availability of local suppliers.	Private providers can use intermediaries and solidarity-building platforms to negotiate access to subsidized FP inputs. Both sectors need to collaborate to understand the implications of subsidized contraceptives, such as commodity selection, forecasting, and supply chain management, for both parties within HCPNs.
		Challenges in acquiring and maintaining a DOH license to operate	Due to complex and costly requirements, many private providers are hesitant and even	Private sector partners can be involved in designing and planning licensing and accreditation processes with PHBs. Early

Sector	Area	Gaps Identified	Notes	Recommendation
		Challenges in accreditation to PhilHealth	resistant to securing DOH licenses and PhilHealth accreditation.	involvement in the planning stage presents the opportunity to streamline operations and ensure that HCPN requirements are acceptable and understandable to private providers.
	Willingness	Anticipated challenges with payment	Given historical challenges with PhilHealth reimbursements, private providers require greater clarity on the mechanics of prospective payments for FP and how they will impact their profitability. There is uncertainty as to whether an HCPN setup will avoid the previous issues they faced with delays and non-payment of claims by PhilHealth.	To increase transparency on the mechanics of prospective payments and implement payment methods that best fit the context of HCPNs, PHBs must collaborate with private sector partners to co-create and adaptively manage reimbursements for FP services.
		Complex claims procedures with high rates of rejection	Many private providers need more computer literacy skills and reliable internet to submit claims for FP on the electronic system successfully. PhilHealth's current electronic system does not have a mechanism to inform private FP providers of the status or outcome of their claims.	Public and private sector stakeholders should explore opportunities to simplify claims procedures by reducing the number of steps and implementing a system that is not reliant on consistent internet connectivity. An improved claims system should provide regular updates on the status of claims and the reasons for any rejections or delays. Private providers should also consider working with intermediaries or provider networks to share best practices and strategies for navigating the claims system that can be easily conveyed to other providers.
		Limited guidance exists regarding how private providers may be legally contracted into HPCNs.	Private providers are reluctant to participate in HCPNs without clear contracting agreements and integration processes. This hesitancy is due to a fear of excessive regulation that would disadvantage their businesses.	Public and private sector partners should prioritize establishing trust and clear communication channels. This may involve organizing regular meetings or forums, such as the PHB convenings, to provide private providers with an opportunity to voice their concerns and provide feedback on the contracting and integration processes. Furthermore, HCPN

Sector	Area	Gaps Identified	Notes	Recommendation
				contracting arrangements should be (co)designed with private providers in mind, considering their potential contributions, capabilities, and interests while ensuring compliance with regulations.
		Low-cost recovery rate and limited profitability for services delivered within the HCPN context	Based on historical experiences, evidence of insufficient reimbursement for services and subsidies for commodities and reduced profitability are noted as significant concerns for private providers when engaging with the public sector.	Public and private sector stakeholders can jointly review payment rates for FP services in the planning of HCPNs and consider private sector perspectives in the implementation phases to ensure that rates are appropriate. The proposed rates could be analyzed and validated by an impartial third party to ensure that the payments for providing FP services align with the operational costs expended. Private providers can collaborate with professional associations or team up with other providers to leverage their collective bargaining power and negotiate better reimbursement rates and subsidies.
		The administrative and procedural burden of participation in HCPNs	Private providers are hesitant regarding their capability to align and comply with the system requirements and adaptations needed to participate in HCPNs. Private providers feel overwhelmed by the possibility that they will need to learn many processes and systems.	The regulations for HCPNs should be co-designed with input from the private sector to identify opportunities for streamlining operations and developing practical administration guidelines conveyable to this cadre of providers. An established intermediary should offer targeted onboarding, training, and coordination support to private providers to manage administrative practices and requirements adaptively throughout the lifecycle of HCPNs.

Sector	Area	Gaps Identified	Notes	Recommendation
		Concerns about the public sector's willingness to engage with the private sector on fair and equitable terms	Based on historical experiences before the UHC Act, private providers must be convinced whether the public system will see them fairly and collegially.	PHBs should engage the private sector early and often to establish a culture of collaboration and transparency. Private providers can work with intermediaries as facilitators to represent their interests in the PHB and build more robust relationships with the public sector in the design of HCPNs.
		Limited knowledge of HCPNs and the private sector role within them	Private providers need better awareness of the HCPN concept and more experience in public-private partnerships.	To ensure a clearly defined value proposition for engagement, private sector partners can participate in the design and planning processes of HCPNs. Additionally, intermediaries and provider communities can provide a platform to assist private providers in learning about and reinforcing the purpose, functions, and operations of HCPNs.