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Perspectives from Healthcare Providers: A Qualitative Evaluation of PhilHealth's Healthcare Provider Performance Assessment System (HCPPAS) in the Philippines

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Abstract

Background

The Philippine Universal Health Care Act mandates strategic purchasing of health services and the establishment of quality assurance mechanisms. Central to this agenda is the Health Care Provider Performance Assessment System (HCPPAS), designed to monitor provider performance and reinforce accountability. Despite its policy significance, little qualitative evidence exists on how HCPPAS is understood and implemented at the facility level. Objectives: This study aimed to explore stakeholder experiences and perceptions of HCPPAS implementation across government and private health facilities in the Philippines. Methods: A qualitative strand of a mixed-methods evaluation was conducted through key informant interviews and focus group discussions in selected hospitals, City Health Offices, and Rural Health Units. Results: Findings revealed gaps in awareness and training, weak institutional support, and fragile digital infrastructure. Monitoring was often viewed as reactive and punitive, with minimal feedback. Conclusion: While aligned with UHC goals, HCPPAS remains constrained by systemic and cultural barriers.

INTRODUCTION

Universal Health Care (UHC) aims to ensure access to essential health services without financial hardship and has demonstrated contributions to improved health, economic growth, and social development[1 2 3 4]. Achieving this requires coordinated responsibilities among government institutions to promote equitable access, quality, and accountability[5] The Philippine Health Insurance Corporation has institutionalized quality assurance mechanisms, including the Health Care Provider Performance Assessment System (HCPPAS)[6]. Introduced in 2014 and formalized through DOH–PhilHealth Joint Administrative Order No. 2021-0001, HCPPAS links provider performance with reimbursement and incorporates standardized indicators, benchmarking, and feedback mechanisms. Despite its policy relevance, evidence on its implementation and effectiveness remains limited, particularly regarding stakeholder experiences and contextual influences[7 8 9]

Regional and global literature similarly highlight gaps in linking health financing mechanisms to healthcare quality and emphasize the need for systematic performance assessment, reliable data, and multi-method approaches[10 11 12] In the Philippines, evidence on workforce and institutional factors affecting performance remains limited, although pay-for-performance initiatives have shown improvements in care and access.[13 14]

This study examines the contextual, organizational, and experiential dimensions of HCPPAS implementation. It explores how the system is implemented, governed, and perceived across health facilities, recognizing that performance assessment systems operate through both technical metrics and institutional dynamics. By capturing stakeholder perspectives, the study identifies awareness gaps, implementation barriers, and policy enablers that quantitative indicators alone cannot explain, informing recommendations aligned with UHC goals of equity, quality, and financial protection. International experience underscores the importance of governance, auditing, transparency, and feedback in strengthening performance systems[15 16 17 18 19] while also cautioning that limited capacity can reduce these mechanisms to routine compliance rather than sustained improvement[20]. These insights guide the study's focus on implementation challenges and system refinement.

METHODS

The qualitative component of this mixed-methods study examined implementation experiences, stakeholder perceptions, and contextual challenges related to HCPPAS. Using a descriptive qualitative design, it captured perspectives on adequacy, appropriateness, reliability, and implementability within the Philippine Universal Health Care Act. This report focuses on the qualitative strand, exploring policy implementation and institutional dynamics not captured by quantitative indicators. The quantitative component is reported elsewhere, enabling in-depth analysis within a coherent mixed-methods inquiry.[21]

Participants and Sampling. Government and private facilities accredited by the Philippine Health Insurance Corporation, from Level 3 hospitals to RHUs/CHOs, were eligible. Key informants were drawn from randomly selected facilities in Bulacan,

Muntinlupa, Negros Oriental, and Davao del Sur, with nationwide selection witnessed by the Department of Science and Technology – Philippine Council for Health Research and Development. Informants were purposively sampled to capture diverse perspectives on HCPPAS implementation.[222324] Inclusion covered healthcare providers, administrators, and stakeholders involved in HCPPAS; non-accredited facilities and those not engaged were excluded. Participants were recruited through local executives and facility heads, with voluntary participation and informed consent facilitated by health offices and management.

Qualitative Instrument Pre-testing: Instrument pre-testing allows researchers to assess how participants interpret questions and the clarity of data collection tools prior to implementation.[25] Semi-structured interview and focus group discussion guides were pilot-tested in Luzon, Visayas, and Mindanao before nationwide data collection. The process assessed clarity, cultural appropriateness, sequencing, and ability to elicit meaningful responses. Feedback informed refinements, strengthening rigor and aligning instruments with study contexts.[26]

Data Collection and Analysis. Data were obtained through key informant interviews (KIIs) and focus group discussions (FGDs) using semi-structured guides, conducted between December 2024 and May 2025 by trained researchers. Sessions were held face-to-face in public and private Philippine Health Insurance Corporation-accredited facilities and RHUs/CHOs. All were audio-recorded with consent, with field notes taken to supplement recordings. Data collection followed standardized procedures, and recordings were transcribed verbatim and analyzed manually using thematic analysis.

Data Triangulation. To establish the credibility and confirmability of the findings, data triangulation was conducted via Zoom sessions with participants from all healthcare facilities included in the study. Preliminary findings were presented, followed by open forums and structured question-and-answer discussions. Feedback from these sessions was used to validate themes, ensure accurate representation of participants' perspectives, and refine interpretations.[29,30,31]

Disclosure

on Use of AI Tools. Artificial intelligence tools were used solely to enhance grammar and language clarity. No AI tools were used for data analysis, interpretation, or generation of study findings.

Ethical Considerations. This study was conducted in accordance with established ethical standards for research involving human participants. Prior to commencement, the study protocol received an exemption certificate from the Department of Health–Single Joint Research Ethics Board (DOH-SJREB) under protocol code SJREB-2024-66. Ethical clearance was also secured from Silliman University Medical Center Foundation Incorporated (SUMCFI) (Reference number SUMC-REC-2024-026). Participation was voluntary. All participants were provided with information about the study's objectives, procedures, risks, and benefits, and informed consent was obtained in writing before data collection. Confidentiality and anonymity were maintained, and data were handled securely.

RESULTS AND DISCUSSION

The results are drawn from in-depth interviews with 88 healthcare workers across Bulacan, Muntinlupa, Negros Oriental, and Davao del Sur. Participants were randomly selected from public and private facilities, including Level 3, Level 2, and Level 1 facilities, as well as City Health Offices (CHO) and Rural Health Units (RHU), representing perspectives from tertiary hospitals to primary care and local health system implementers.

Cross-Cutting Themes Across Health Facilities in the Four Areas. Cross-Cutting Themes Across Health Facilities in the Four Areas. This section presents an integrated interpretation of qualitative data on the implementation and awareness of HCPPAS of the Philippine Health Insurance Corporation. It synthesizes patterns and examines experiences across facilities and implementers through key themes and challenges. It evaluates HCPPAS in real-world settings in terms of adequacy, appropriateness, reliability, and implementability, consistent with findings that performance systems produce context-dependent outcomes influenced by local constraints and system capacities.[8] The discussion situates HCPPAS within the

Universal Health Care (UHC) Law, assessing alignment with strategic purchasing, quality service delivery, and equitable health outcomes.

Area 1: Variations in Awareness, Tool Application, and Policy Support Affect System Effectiveness. This section synthesizes qualitative data across health facilities in Bulacan, highlighting factors that limit HCPPAS effectiveness. A key finding is the lack of awareness among healthcare personnel in public and private facilities, with many encountering HCPPAS only during the study. The absence of structured orientation and training has led to uneven understanding of PhilHealth circulars, standards, and reporting requirements. Facilities relied on self-initiated learning, reducing consistency and tool reliability, and positioning HCPPAS as reactive. One respondent noted: "There is a real shortage of staff… our trained staff are dazzled by other offers and leave, so we end up training our own repeatedly." This reflects staff turnover, weak retention, and strain on capacity-building, contributing to errors, ethical dilemmas, and burnout, a pattern linked to poor health-care system performance in resource-constrained settings.[32]

The inconsistent application of tools such as chart reviews, exit surveys, and the e-Claims system illustrates implementation gaps. While the Patient Exit Survey is well-received and e-Claims improves workflow, effectiveness is limited by poor onboarding and weak internet connectivity, impairing data quality and performance.[33] Data reliability and claims efficiency are affected, with lower-level facilities relying on manual workflows due to limited infrastructure. Monitoring mechanisms, including RFSOA and domiciliary visits, are conducted nominally, limiting oversight. At the policy level, unclear guidelines create ethical tensions, particularly in financial claims, with blame often placed on frontline workers despite structural issues, reflecting misaligned incentives in performance-based financing.[34]

Despite these challenges, financial protection mechanisms associated with HCPPAS such as DOH-Malasakit, No Balance Billing (NBB), and Zero Co-Pay for private hemodialysis packages have been meaningful for patients, reducing out-of-pocket expenses for inpatient services, consistent with evidence that financial protection policies improve access and reduce catastrophic spending.[35] However, diagnostic exclusions and outpatient gaps limit protection. Healthcare staff's lack of clarity on these benefits reduces their capacity to communicate entitlements, affecting effectiveness at the point of care and highlighting the importance of frontline understanding.[36] In Bulacan, HCPPAS struggles due to fragmented systems, inconsistent training, and weak policy support. Positive patient experiences are not always representative of overall system functionality. Institutional coherence, standardized capacity-building, and clear policies are essential to bridge gaps between design and practice.[34] Strengthening these can improve implementation, empower personnel, enhance data reliability, and ensure HCPPAS functions as a mechanism for quality assurance and financial protection.

Area 2: Perceptions of Enforcement and Variations in Support Systems. In Muntinlupa, HCPPAS implementation is constrained by limited training and unclear understanding of system mechanisms, resulting in inconsistent, complaint-driven assessments, reflecting how insufficient capacity leads to reactive monitoring.[8] Respondents noted that facilities rely on complaints rather than proactive tools, limiting the system's ability to prevent quality lapses. This approach reinforces perceptions of oversight as punitive rather than constructive, which can reduce provider participation and hinder quality improvement.[34]

Technological and infrastructural gaps worsen these limitations. While some facilities use electronic medical records (EMRs), effectiveness is constrained by unstable internet, outdated hardware, and system incompatibilities, leading to inefficiencies and reliance on manual processes. Low-level facilities also face medicine stockouts and logistical bottlenecks, further straining operations, a pattern linked to inadequate service delivery in resource-constrained systems.[36]

A challenging dimension is the environment surrounding field monitoring, where inspections are often perceived as punitive, leading to fear, mistrust, and occasional resistance among personnel. This can affect engagement and data quality, while staffing shortages, legal vulnerabilities, and limited safeguards contribute to burnout. Financial protection under HCPPAS also shows gaps, as zero-billing under No Balance Billing (NBB) is affected by claim denials due to administrative errors, creating delays for providers and patients.[35] HCPPAS in Muntinlupa functions more as a compliance-oriented system than a learning

one, indicating the need for clearer processes, improved digital support, and stronger mechanisms to support field personnel and enhance outcomes.

Area 3: Support Limitations and Systemic Challenges in Rural Health Facilities. In Negros Oriental, HCPPAS faces challenges in rural settings, including limited visibility, inadequate resources, and gaps between policy and practice. Most healthcare personnel encountered HCPPAS only during the interviews, indicating minimal orientation or training, consistent with evidence that implementation depends on local capacity and engagement.[37] Few learned informally through peers, weakening accountability and adoption.

Technological deficits further constrain implementation. Facilities rely on a single shared laptop and unstable internet, delaying claims and data management, aligning with findings that digital and interoperability gaps hinder performance systems.[38] Private facilities depend on donor funding, while PhilHealth support remains limited, raising sustainability concerns. Financial protection is uneven, with some clinics offering zero out-of-pocket costs, but low enrollment persists due to external barriers and HCPPAS not handling registration. Private hospitals report claim denials linked to unclear standards.

Service gaps worsen inequities. Minor procedures, outpatient care, and emergency services are often excluded, affecting lower-tier facilities that charge patients directly. Staffing shortages require multitasking across clinical and administrative roles, limiting implementation. Communication gaps persist, as claim denials are not part of HCPPAS, which monitors paid claims. One respondent noted: “We don’t have a point person… many are kept denied due to lack of ordinance or clear process.”

There was strong consensus on the need for practical, regular, and accessible HCPPAS training in rural and resource-limited settings to address knowledge gaps and improve functionality. Experiences show that while HCPPAS aligns with Universal Health Care, its effectiveness is constrained by reactive monitoring, punitive perceptions, fragmented support, and resource inequities, consistent with evidence that performance-based reforms produce mixed and context-dependent outcomes without strong system alignment.[39] Strengthening training, digital infrastructure, and institutional support is critical to transform HCPPAS into a learning-oriented system for equitable quality improvement.

Area 4: Variations in Awareness, Tool Adequacy, and Systemic Challenges. Findings from Davao del Sur show structural, operational, and governance challenges that limit HCPPAS implementation. Awareness among health workers is low, with most encountering HCPPAS only during interviews. Reliance on circulars and peer learning, without formal orientation, has led to uneven use of tools and indicators, many of which are not suited for services such as maternal health, dialysis, and TB-DOTS. One respondent noted: “For HCPPAS, we view it as a quality monitoring system… but some issues are not captured, so we assess them manually.” Staff rely on self-learning or remain unexposed to guidelines, weakening the reliability and utility of performance data, consistent with evidence that performance-based systems produce varying results when tools and implementation are not aligned with local settings.[39] Infrastructure and digital limitations exacerbate constraints, with unstable internet, inadequate systems, and reliance on personal devices delaying claims and contributing to burnout. Human resource shortages, high turnover, and lack of clear SOPs disrupt service delivery and data consistency, while limited feedback mechanisms prevent timely correction. Financial protection through e-Konsulta and No Balance Billing (NBB) remains uneven, with denied or delayed claims creating hardship and access dependent on connectivity, accreditation, and local capacity.

Addressing these requires tailoring tools to facility types, strengthening capacity-building, improving rural infrastructure, instituting feedback mechanisms, and aligning reimbursement with real costs. Without these, HCPPAS cannot achieve its potential under UHC.

CONCLUSION

The qualitative inquiry indicates that while HCPPAS is valued for accountability, patient protection, and quality assurance, its effectiveness is constrained by operational and systemic barriers. Stakeholders report limited training, staff shortages, overlapping roles, and heavy workloads leading to superficial audits and incomplete follow-up. Infrastructure and digital gaps

—unstable internet, manual records, and fragmented systems—limit feedback, while checklist-driven tools fail to capture clinical realities. These contribute to perceptions of reactive and punitive monitoring, despite patient-centered practices and some gains in financial protection.

Realizing HCPPAS's potential requires strengthening training, modernizing tools, and improving digital infrastructure for reliable data and feedback. Independent verification can enhance trust, while feedback loops and dialogue can shift monitoring toward learning and improvement. Anchored in equity, patient-centeredness, and accountability, these reforms can transform HCPPAS into a learning-oriented platform; without them, it risks remaining a compliance exercise disconnected from frontline realities.

Declarations

Conflict of Interest

The authors declare no conflicts of interest. The views and conclusions expressed are solely those of the authors and do not necessarily reflect those of their affiliated institutions.

Author Contribution

● MRB: Lead writer of this article, with substantial contributions on the collection, analysis, and interpretation of data related to health governance, public health, and health financing, which were critical in shaping the study's findings, conclusions, and recommendations. Contributed to drafting the manuscript, approved the final version for publication, and agreed to be accountable for all aspects of the work. Co-wrote the paper and led the integration of qualitative and policy analysis to ensure rigor and coherence in the research narrative.● JGT: Substantial contributions on framing the analysis specifically in the concepts of traditional health medicine, community development, that are useful in creating the research results and conclusion; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.● JRN: Substantial contributions on analyzing raw data and interpreting them through the author's expertise in public health, health governance, healing financing, that are useful in the formation of the research results, conclusion, and recommendation; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.● KRU: Substantial contributions on interpreting raw qualitative data through the author's expertise in public health and public management; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.● EOA: Substantial contributions on interpreting and analyzing data through the author's expertise in public health and health financing; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.● NS: Substantial contributions on framing the analysis and design of the research in both quantitative and qualitative data; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.● IC: Substantial contributions on framing the analysis and design of the research in both quantitative and qualitative data; contributions on drafting the work, approval for publication, agreement to be accountable for all aspects of work; co-wrote the paper.

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