Health insurance in the Philippines: bold policies and socio-economic realities

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Abstract

In 1995, the Philippines government legislated to create an income-rated and predominantly employment-based universal health insurance program over a 15-year period. The program was intended to provide more and better health care than was available through a combination of existing insurance schemes that covered less than half of the population, and partially subsidised services provided by government facilities and funded from general taxation.
The legislation was well intentioned, and the program has some skilful and imaginative staff. However, there are significant barriers to success including low average and widely dispersed incomes, improving but still unsatisfactory health status, weak government health care services, and the sometimes negative impact of for-profit agencies.
We review progress to date and conclude that, although membership numbers and benefit rates have increased, access is still inadequate and copayments are high. We argue that strong and innovative steps are needed if the Program's goals are to be realised. In particular, we suggest that the focus should be on more formal and explicit rationing that takes account of cost per quality-adjusted life-year; and radical adjustment of financial incentives for care providers including capitation and per case payment based on costed clinical pathways for high-volume case types. Finally, we comment briefly on lessons that might be learned by both The Philippines and Australia.

The context

There are several excellent descriptions of the Philippine health system. This section provides a brief summary of the context, drawing mainly on government publications.

Health status

The health status of Filipinos has been improving at an increasing rate over the last 20 years. Inter alia, death rates are declining, and some causes of morbidity and death including infectious diseases have been effectively controlled.

However, the Philippine Department of Health (1999a) concedes that progress has not been as rapid as in many other similar countries. Birth rates are relatively high, and have declined only slowly for several reasons, including the cultural constraints to birth control due to the predominance of Roman Catholicism. The infant mortality and maternal mortality rates have declined, but are still much higher than one would expect from the economic, educational, and social indicators. In 1995, only Indonesia had a higher maternal mortality rate among southeast Asian countries.

The concerns are compounded by wide variations within the Philippines. In 1995, the infant mortality rate in the worst province (Lanao del Sur) was 69 per 1000 live births - more than twice the rate in the best province, Bulacan (NCSB, 1998).

An underlying reason for slow rates of improvement is that many common illnesses of poverty (including infectious diseases that are associated with unsafe water) have been inadequately managed. An example is tuberculosis (TB), which has been researched by several authors. Tupasi et al (2000) concluded that it remains a substantial cause of illness and death, especially in the urban poor settlements. Wallerstein (1999) reached a similar conclusion in a study of urban slums.

Tupasi et al (1999) reported the results of a 1997 national survey of the prevalence of TB. They found similar levels in urban and rural areas and concluded that there had been only minor decline since the previous survey in 1983. Auer et al (2000) investigated TB case finding and treatment and concluded that inefficiencies in case finding and poor communication between health professionals and the community were significant constraints.

Another example is vitamin A deficiency. Fiedler et al (2000) reported the largely unchanged prevalence rates, and argued that inadequate funding and poor targeting are underlying causes of unsatisfactory progress. Espino and Manderson (2000) studied malaria diagnosis and treatment in a rural area. They identified several weaknesses including inappropriate dosages of antimalarials.

In addition to these long-standing problems, the Philippines is coming under increasing pressure from diseases of development. In particular, social and economic changes are creating challenges in terms of degenerative diseases, and expectations for care are rising within an increasingly more powerful middle class.

For example, Reyes-Gibby and Aday (2000) analysed the results of a community health survey directed at assessment of the prevalence of and risk factors for hypertension, and found that the levels were unexpectedly high. They concluded that "... in the absence of fully implemented programs to prevent and control hypertension, the current prevalence is only expected to increase, leading to substantial increases in morbidity and mortality and health care cost."

The challenges are further compounded by growing morbidity associated with increased urbanisation and industrialisation. For example, Suplido and Ong (2000) studied blood lead and haemoglobin levels in workers in battery repair and recycling shops in Manila, and among children living near the shops. They found levels far in excess of the World Health Organisation's permissible exposure limits in both the workers and the neighbouring children.

Health care financing

Health care spending grew from about 3.1% to 3.5% of gross domestic product between 1990 and 1997, but it remains below average for countries of similar wealth. The main sources for all health expenditure in 1997 are shown in Figure 1, and compared with statistics for Australia. In this table and elsewhere, currency is the Peso (P) and the current exchange rate is P25 to $1 Australian.

There is a large difference in health expenditures between the two countries. Per capita health spending in 1997 was about P1280 in The Philippines, only about 2% of that in Australia ($2500 or P62500).

Figure 1: sources of expenditure, all health care, 1997

Source	Expenditure, The Philippines			Expenditure, Australia		
	Total (P billion)	Per capita (P)	% total	Total (P billion)	Per capita (P)	% total
National government	18.7	271	21.2	609.0	32500	52
Local government	15.5	224	17.5	269.4	14375	23
Government-operated insurance	6.4	92	7.2	—NA—	—NA—	—NA—
Out-of-pocket	41	594	46.4	187.4	10000	16
Private insurance	6.9	100	7.8	105.4	5625	9
All sources	88.4	1280	100	1171.2	62500	100

For the most part, costs per unit of service are lower in The Philippines because of the much lower incomes. However, the lower costs only explain a fraction of the differences in per capita spending. For example, the average tertiary hospital charge for inpatient care was P13750 in 1997, which was about 20% of the average cost in Australia.

In a few cases, unit costs are higher in The Philippines. A good example is drugs: commercial prices are sometimes double those applying under Australia's Pharmaceutical Benefits Scheme. The government has attempted to reduce prices by importing in bulk and selling under generic labels. Unfortunately, partly as a consequence of corruption, the generic drugs are widely mistrusted due to bad publicity regarding efficacy and health risk. In total, utilisation is a more important determinant of lower health care spending in The Philippines than unit costs.

National and local government financing is mostly from government general revenue. Local governments have few opportunities to raise financing themselves, and they rely heavily on transfers from the national government.

Government-operated insurance largely comprises the National Health Insurance Program, or simply the NHIP in this paper. While the NHIP is government-owned and operated, the large majority of its revenues are obtained directly from members' contributions. The government's financial assistance is limited to payment of premiums on behalf of some disadvantaged groups termed 'the indigent' in the context of health insurance in The Philippines.

Note that self-pay (out-of-pocket) is the largest single source. It accounted for 46.4% of the total in 1997, and has been at about this level for twenty years or more.

Indeed, the only significant change in shares over the last decade has been a gradual increase in local government expenditures and a corresponding decline in national government contributions. This has been a direct consequence of the government's policy of devolution after 1991, which has been applied in many sectors and not only to health care.

Private insurance is of two main types. First, there are various commercial companies that offer cover mainly for the well off and for employees of larger and financially secure enterprises. Unlike private health insurance in Australia, which mostly finances inpatient services also covered by government insurance, Philippine private schemes predominantly address the gaps in government insurance and subsidised services. Cover is usually low-cost, and concerns the kinds of ambulatory services that are not covered by the NHIP or available at subsidised prices from government-financed clinics. Commercial agencies tend to be aggressive in terms of utilisation control, and it is common practice for utilisation staff employed by the insurer to supervise most episodes of care on a concurrent basis.

The second kind consists of what are termed community health insurance schemes. They are mostly mutual associations with restricted membership by geographical area. Service coverage is usually limited to primary care and basic treatment services.

These schemes are a response to the realities of poor rural communities, where access is restricted by both poverty and inadequate supply of services. In The Philippines, as in many similar countries, government insurance has focussed on salaried government and private sector employees, and other sectors of the population have had to rely on their own efforts to a significant degree. The justification has often been that the informal sector presents more difficulties in terms of the collection of insurance contributions. However, it may also be relevant that the informal sector tends to be less wealthy and articulate.

A few community health insurance schemes have been innovative and highly successful, but the level of penetration is extremely low nationwide. For example, Ron (1999) reported an evaluation of the ORT Health Plus Scheme in several rural communities, and concluded that it had made health care affordable and accessible to the target population. He argued that schemes of this type have much potential, but a complicated design is required that deals with the many barriers in an integrated way. He suggested that government health agencies should help more by way of "... national guidelines, a formal accreditation process and an umbrella organisation to provide assistance in design, training and information services ... involving government, non-government and academic institutions as an integral part of the development process."

Health care services

Health expenditure is dominated by personal health care, although there has been an increase in the share of expenditure on public health care services in the last decade (from 8% in 1991 to 12% in 1997). Spending on personal health care is mainly for hospital services (50%), ambulatory medical care (20%), and drugs (25%).

Health care is provided by a mix of government and non-government agencies. The central and local governments provide basic emergency care in hospitals, child and maternal care services through clinics, and public health services including safe water and other environmental health programs. The Philippine government has worked hard to improve the quality and accessibility of primary health care through various programs, but success has been limited (Heinonen et al 2000).

Most primary medical care is provided on a fee-for-service basis by private practitioners. Specialists are also mostly private practitioners who work in both government and non-government facilities. They typically have a significant private practice and (like most doctors in Australian private hospitals) bill separately from the hospital.

The Philippines defines three levels of hospitals in the referral system. Primary is the most basic, and typically comprises small hospitals in rural areas with minimal inpatient facilities. The tertiary level includes major teaching hospitals in urban areas, a few of which provide medical care of a standard approaching that in Australian teaching hospitals in some respects.

Figure 2 shows that most care covered by the NHIP is provided in tertiary hospitals. This reflects the fact that membership is currently skewed towards the middle and upper classes, and towards urban dwellers. However, the overall level of hospital utilisation shows a similar pattern. The uninsured make relatively little use of hospitals of any kind, except for urgent care.

Figure 2: NHIP benefit payments by hospital level and ownership, 1999

Hospital category (referral level)	Hospital ownership					
	Government		Private		All hospitals	
	P million	%	P million	%	P million	%
Primary	25.63	0.90	91.3	3.19	116.93	4.08
Secondary	163.79	5.72	375.9	13.13	539.69	77.07
Tertiary	594.18	20.75	1612.60	56.32	2206.78	77.07
All referral levels	783.6	27.37	2079.8	72.63	2863.4	100.00

Most hospitals are private in all three referral levels. The majority are non-profit, and particularly religious. There are fewer for-profit hospitals, but they have increased their share in recent years.

Weaknesses that the new insurance scheme was intended to alleviate

Health care in the Philippines is predominantly low-cost and of variable quality. The services are of particularly poor quality in many rural areas, and especially in the more remote settlements where health care professionals are in short supply and facilities are inadequately equipped and maintained.

Copayments are common for most kinds of services, and many Filipinos cannot afford to pay for needed care. In some more remote areas, services may be unavailable at any cost. The inequities are obvious from many statistics. For example, in 1993 only 25% of people in the poorest quartile consulted a doctor in the previous six months whereas 48% did so among people in the richest quartile (Department of Health, 1994).

This is to be expected, given uneven and generally low levels of income of most Filipinos. There are differences of opinion as to whether cost-effectiveness could be higher in the circumstances, but the general problems are hardly disputed.

First, although primary care has had more impact on health status than any other level of health care, it has not yet come close to realising its potential. There are many structural and resourcing weaknesses that need to be resolved. For example, Streefland, Chowdhury and Ramos-Jimenez (1999) point out that the child immunisation programs have delivered many benefits in most of the Philippines. However, there continue to be many "... serious shortcomings in the quality of the routine vaccination services" including poor communication with parents, breakdowns in the supply chain, and missing or dysfunctional facilities and equipment. They argue that the shortcomings "... are detracting from the sustainability of routine vaccination programs and are promoting the growth of pools of non-immunised and partially immunised children."

The underfunding of primary care is widely recognised. For example, Secretary for Health stated in 1999 that "... too large a proportion of health care financing goes to hospitals, and to tertiary hospitals in particular." It is not only that some hospital services are of low value for money compared with primary care. Most Filipinos are not within easy reach of tertiary hospitals or cannot afford to be treated there.

Second, public health programs need to be more cohesive and consistent. A recent planning document from the Department of Health argues that there should be multi-year budgets for public health programs, and staff need to be upgraded. This is necessary if they are to take a more proactive approach to public health, and to avoid the inefficiencies resulting from unpredictable budget fluctuations (Philippine Department of Health, 1999b).

Third, most care providers (and especially lower-level government hospitals and clinics) are deficient in terms of the ideas of total quality management. They tend to deliver services without a clear idea of their quality, have not developed a culture of learning and continuous improvement, fail adequately to stimulate and improve their staff, and so on. The situation has been changing slowly, especially in the tertiary hospitals and in privately owned hospitals in the major urban areas, but much remains to be done.

Fourth, there needs to be more concern for and greater skill with respect to cost control. The normal methods of payment of private hospitals is fee-for-service, which encourages over-use. Public sector care providers have typically been funded by annual budgets based on expenditure history. The government has begun to corporatise facilities in recent years, and this has been associated with reductions in budgets and encouragement of direct billing of insurers and individual patients. However, the new basis for payment is largely fee-for-service, thus creating the same weaknesses as those applying to private hospitals. Supplier-induced demand is obvious from many statistics, including the high caesarean section rates.

Fifth, most care providers (and particularly the government-owned hospitals and clinics) have not yet become consumer-oriented. A recent government report (Philippine Department of Health, 1999b) argues that "... government hospitals must be made more responsive to health needs" and proposes that this might best be achieved through increasing the extent to which they must compete in the marketplace by way of corporatisation as outlined above.

Sixth, most care providers (and especially primary and secondary care providers in rural areas) are deficient in skilled staff and equipment. They would need to have their facilities upgraded and their staff skills enhanced in order to be able to evolve into learning organisations - and "... to be competitive in a socialised market place" (Philippine Department of Health, 1999b).

With a few exceptions, the main workforce problems are not numbers but rather maldistribution, and deficiencies of skill or motivation. In a recent study of the dental workforce, Mabunga and Parajas (1999) argue that there are serious problems arising from "... an unequal distribution of dentists as well as a large amount of wastage in the production of dentists."

Similar problems exist in the medical workforce, and the government continues to have difficulties in creating incentives for doctors to work in rural and remote areas. For example, metropolitan Manila accounted for only 17% of the total population of 76 million in 2000, but had about 38% of doctors and 55% of specialists.

Seventh, control over health care providers needs to be increased in many ways. The government acknowledges the need for regulatory agencies to be strengthened "... so that they can be more effective in enforcing rules regarding health in such areas as food safety, safe water, and high quality health care services" (Philippine Department of Health, 1999b).

The need for greater control over hospital pricing is indicated by the experience of the NHIP in 1999, when it increased the levels of benefit payments with the intention of reducing members' out-of-pocket payments. In the event, hospital charges rose accordingly, and more than outweighed the increase in benefit payment rates.

Eighth, the weaknesses of decentralised management need to be addressed. The Secretary of Health (Philippine Department of Health, 1999b) argues that the devolution of responsibilities for health care to local government units "... was done with noble intentions" but resulted in "... inappropriate and ineffective health service implementation" because of inadequate preparation. As a consequence, the hospital system is "weak" and there is "... an uneven distribution of the health workforce." The skills of local government staff need to be enhanced - not only in health care issues but also in management of finances and of interactions between government, private, and volunteer agencies.

Ninth, there are serious weaknesses of co-ordination between hospitals and community-based care providers, and between public health and personal health services. It is widely recognised that fragmented financing processes encourage the shifting of costs and problems, and that care is frequently disjointed as a consequence of a lack of incentives for co-ordination across care settings.

Finally, relatively little has been done with regard to health promotion and illness prevention. For example, there are high rates of avoidable accidents, and low compliance rates with legislation on seat belts and the wearing of crash helmets by motorcyclists. There are low levels of recreational exercise, and weak policies regarding smoking (partly as a consequence of the political power of local tobacco growers).

The new health insurance scheme

The need to increase access (by increased levels of financing and in other ways) has long been recognised, and this led to a prolonged debate about methods in the early 1990s. Several approaches were given consideration during this period, including privatisation of health insurance along US lines, and the establishment of a single-insurer government-operated scheme financed from general revenue along Canadian lines. In the event, a mixed model was chosen, whereby there would be a compulsory government-run scheme based mainly on employment-based contributions together with voluntary private health insurance for additional benefits. The choice was influenced by the following views:

- health insurance based on social pooling is too important a matter to be left to non-government agencies
- there should be a separation of health care financing and purchasing from the delivery of health care, and therefore the Department of Health should progressively reduce its involvement in the former
- government insurance should be restricted to ensuring basic benefits for the whole population, and the operation of additional optional insurance schemes should continue to be handled by the private sector for various reasons (including the view that, because it is inequitable, the government should not be directly involved)
- it would be easier to collect premiums if most members were required to contribute by way of their employer, in view of the weaknesses in taxation systems
- there was a general trend in this direction in other developing economies such as China, Thailand, and several countries in eastern Europe (influenced in part by the World Bank and other international agencies)
- the government already had experience in running this type of scheme, since it had been operating two small insurance funds since the mid-1980s.

Other reasons were given by some parties. For example, it was not unusual to argue that a new approach was needed, but the Department of Health was too bureaucratic and inertia-bound to be able to innovate. Similarly, it was sometimes claimed that there would be less direct criticism of the government if a separate agency were established.

There has been an ongoing debate about privatisation, especially with respect to care provision. The government has argued it is appropriate in most sectors including health, and has claimed support in this matter from the World Bank. However, the potential negative consequences are well recognised. For example, Basilio

(2001) discusses the risks to equity. He notes recent experiences in the corporatisation of government hospitals - like Malaysia, public opposition was a major factor in causing privatisation plans to be shelved. He cites the recent example of the Tondo Medical Centre in Manila, where the original intention was complete privatisation. Under the new model, the Centre has been corporatised, and permitted to construct a new annex reserved specifically for self-pay patients. Thus the government gave a clear indication of its willingness to apply "... double standards" in spite of its public claims about equity for all. There are similarities in this regard to the process of collocation of private and public hospitals in Australia.

There was much less debate about the degree of privatisation that was appropriate for health care financing. The government was adamant about the need to retain tight control, and few people took a different view. In the event, a simple model of the purchaser-provider split was chosen, even though there is little evidence of the benefits of this model from anywhere in the world (Muetzelfeldt, 1999).

The National Health Insurance Program was established by the National Health Insurance Act of 1995, with minimal opposition. A new government agency, the Philippines Health Insurance Corporation (PhilHealth), was created to administer the Program.

Transitional issues

The two existing government insurance schemes covered about 23% of the population in 1995. Medicare I was compulsory but restricted to government employees and pensioners. Medicare II was largely voluntary, and intended to provide similar benefits for individuals and employers who were not eligible for Medicare I.

The aim was to extend membership to all Filipinos over a 15-year transition period. It was recognised that creation of an equivalent level of insurance benefits was not affordable in the short term. A much lower level of benefits would be necessary.

This created a potential problem, in that the government had decided that the goal should be equal benefits for all. This difficulty was alleviated by defining a five-year transitional period: basic benefits would be provided to all, but members of the old schemes would also receive 'supplementary benefits' to the level of those schemes. Over the five years, benefit levels would be equalised by upgrading the basic benefits package.

Equity of contributions and benefits

The Act is a model of social justice for the most part. Of particular importance, all members should receive the same benefits: access to care "... must be a function of a person's health needs rather than his ability to pay." Contributions must be income-rated, and set to zero for some groups including pensioners belonging to the old Medicare schemes, new retirees that have contributed for at least 10 years, and indigents (persons and families with low incomes).

Universal coverage

All Filipinos will be required to be members of the Program in due course. The Act notes that the main constraint to rapid implementation of universality would be service access: before requiring enrolment, PhilHealth "... must ensure that members will have reasonable access to adequate health care services." This is a tricky matter, in that it implies PhilHealth is able to influence supply to a considerable extent.

Beneficiaries are defined to be of two main types: the member (normally an employed or retired person) and dependants. Dependants include the spouse who is not a member in his or her own right, unmarried and unemployed children under age 21, dependent handicapped children aged over 21, and parents over 60 years of age having low incomes.

Financing and member contributions

The Act specifies three main sources of financing. The largest share should be ordinary members' premium contributions. The government should progressively increase its subsidies for indigent members (shared between the national and local governments, but moving progressively towards becoming a local government responsibility). Government grants, including appropriations from taxation sources, should be made for one-off infrastructure developments.

All employers are required to register, and to deduct premium contributions from their employees' salaries and wages and submit them promptly to PhilHealth. Failure to make contributions will not mean that the employee is denied benefits. Rather, the employer will be liable for the costs.

The Act states that ordinary members' contributions must be "... actuarially determined based on variations in risk, capacity to pay, and projected costs of services utilised" and that there should be different premiums "... for specific populations". There is a lack of clarity of intent here. One could interpret this to mean that higher premiums could be set for people in a region with high morbidity or higher than average age. This would be inconsistent with the general policy that contributions must be based only on ability to pay.

Management of the Program

PhilHealth is expected to operate a national scheme that ensures equity and efficiency. However, it is required also to devolve some responsibilities to the local government unit (LGU) level in accordance with the government's broad agenda for decentralisation. It is specifically required to establish local health insurance offices at the provincial and city levels. The local offices are expected to assist with recruitment, collection of contributions, payment of claims, and even the setting of local benefits that are "... at least equal to the minimum package" defined nationally by PhilHealth.

However, the extent of LGU authority and responsibility is not clearly specified in the Act. There is also some degree of inconsistency in that, if the local office specifies benefits in excess of those operating nationally, this may be at odds with the idea of a single national basic benefits package.

Services to be covered: personal health but not public health

The Act points out that the Department of Health must continue to be responsible for public health services, and especially for those services for disadvantaged populations (children, women, displaced communities, and indigenous people). PhilHealth is to focus on personal health services.

Public health services are defined to be those that "... strengthen (health promotion and illness prevention) through improving conditions in partnership with the community at large." They include control of communicable and non-communicable diseases, health promotion, public information and education, water and sanitation, environmental protection, and health status monitoring.

Personal health services are defined in the Act as those where "... benefits accrue to the individual person". They are to comprise both "inpatient and outpatient" services. Most people have interpreted outpatient to mean both hospital and non-hospital ambulatory care.

The Act did not address the many boundary issues. For example, it did not cover the role of hospitals in health promotion, or of care providers that undertake (say) immunisation or screening.

Types of personal health services

The Act specifies elements of inpatient care (room and board, health professional services, diagnostic services, etc) and outpatient care that are to be covered. It also specifies excluded services, as follows:

- non-prescription drugs
- cosmetic surgery
- drug and alcohol dependence
- outpatient care for mental illness
- home care
- rehabilitation care
- optometry
- normal (uncomplicated) childbirth.

However, PhilHealth is allowed to add other services to the benefit package that are "appropriate and cost-effective". It may also exclude any services it determines to be "cost-ineffective".

This is fortunate, since the justification for inclusions and exclusions in the staring list is unclear. For example, drug and alcohol abuse are important social problems that can be effectively treated in some cases. Home care services may be more cost-effective than prolonged stays in hospital, and there is little logic in financing inpatient care for mental illness but not outpatient care.

The level of benefits

For the first five years, PhilHealth was required to provide "a basic minimum package of benefits" that would allow coverage to be extended to "... the widest possible population" of indigents. The package must deliver at least 50% of the benefits of Medicare I in terms of claims cost per beneficiary household.

No direct reference was made to copayments. However, the legislation stated that the new scheme should provide "... maximum relief from the financial burden on the beneficiary". This was intended to imply that members should be protected from catastrophic health care costs, and is one reason why PhilHealth has chosen to use a predominantly proportional rather than (say) a ceiling copayments model.

Choice of care providers

The Act requires PhilHealth to inform its members of the full range of accredited health care providers, so that members may make informed choices. Members should be "... free to choose between accredited health care providers." However, PhilHealth can apply limitations if it has concerns about "... the appropriateness of treatment in the facility chosen."

This implies that PhilHealth may decide that particular forms of care cannot be provided in some hospitals because they lack facilities or trained staff. This has been interpreted to mean that PhilHealth can choose not to contract with a particular hospital for some or all of its services because of quality of care but not because of high prices.

Accreditation of health care providers

PhilHealth is empowered to operate an accreditation program, and care providers are required to be accredited before they can participate in the Program. In order to be accredited, a care provider must have adequate staff and facilities (specified as standards by the Department of Health). It must also have formal quality assurance and utilisation review programs, agree to the payment methods determined by PhilHealth, have adequate referral protocols, recognise "the rights of patients", and provide specified information to PhilHealth.

The requirements are loosely defined. This presumably means that PhilHealth could choose to make them easy or hard to satisfy (and therefore increase or reduce the number of participating care provider organisations).

Care provider payment formulas

The Act allows PhilHealth to choose between fee-for-service (FFS), capitation, global budgeting, and any combination of these approaches. FFS payments "... may be made separately for professional fees and hospital charges." The rates are to be based on a schedule established by PhilHealth, and updated every three years.

FFS payments for professional services provided by salaried staff in public facilities are to be retained by the facility and pooled for distribution among health employees. Payments for services other than professional services are to be used by the public facility for purposes other than salaries (equipment, plant, quality improvement, etc).

Utilisation review

PhilHealth is required to set up monitoring mechanisms through contracts with care providers in order to control the over-use of services, unnecessary diagnostic and therapeutic services, irrational medication, under-use of services, and inappropriate referral practices. Payments may be denied or reduced if utilisation is judged inappropriate or false information is provided to PhilHealth.

Experiences during the first five years

No major changes of strategy have occurred thus far, although some are planned as outlined in the final section. One of the reasons for caution is that of novelty of the task. PhilHealth has many senior staff with a high degree of ability, but few have first-hand experience in the design and operation of this type of insurance scheme. Moreover, many of the junior staff lack relevant skills.

Another general constraint is the lack of clarity of the roles of PhilHealth and the Department of Health. The Act, while well intentioned, compounded the border issues in several ways. As noted above, it directed PhilHealth to focus on personal health care with an emphasis on hospital services, while public health services must remain in the hands of the Department of Health. It failed to clarify the roles of PhilHealth and the Department regarding licensing and accreditation.

Third, there is a long tradition of private medical services, and the private sector as a whole is poorly regulated and relatively influential. While it is not opposed to change in principle for the most part, it has justifiable concerns about risks of poorly designed reforms.

This said, there have been changes of detail in most aspects of operation of the NHIP. The following are some of the most important.

Membership trends are summarised in Figure 3. It should be noted that information systems are weak, and therefore many of the statistics are estimates. One problem is that poor records are maintained for dependents, and another is that claims are unbundled and cannot easily be linked into episodes. It is difficult to distinguish real changes in membership from changes in methods of counting.

Figure 3: trends in membership and benefit payments, NHIP

	1997	1998	1999	2000
Members (millions)				
SSS (Medicare II)	18.60	28.00	22.00	23.74
GSIS (Medicare I)	1.97	6.00	7.71	8.51
Indigents	0.00	0.01	0.42	1.60
Individually paying			0.16	2.18
Total members	20.57	34.01	30.29	36.03
Benefit payments (P millions)	2711	1989	4286	6875

Source: Philippines Health Insurance Corporation, Annual Reports 1996 to 2000

This said, there appears to have been a very satisfactory increase in membership, from about 23% to 48% of the total population. The number of government employees and their dependents has increased steadily. The number of private sector employees has fluctuated wildly. This is mainly a reflection of the economic downturn in 1998 and 1999, which caused many companies to reduce staff, go out of business, or simply to cease payment of contributions.

Coverage has been extended to the main target groups. The scheme for the self-employed (individually paying members) began in early 1999 and has been reasonably successful. The scheme for the indigent began in 1997, and has had many more problems.

A disturbing feature is the variation in utilisation rates across member categories. In 2000, members from the private employment sector had a claim rate per beneficiary-year of 1.4%, compared with 3.2% for members of the government employment sector. For the indigent members, the rate was only 0.3%. The low utilisation rates for indigents reflect three main factors: the high copayments, low expectations, and a lack of knowledge about the program.

While the growth in membership may be considered satisfactory in the circumstances, it will be extremely difficult to achieve universal coverage by 2010, if only because the remaining uncovered segments of the population are those that are the hardest to include for reasons of low income and isolation. In general, the slower rate of progress than expected is probably a consequence of a lack of attractiveness (partly through poor marketing but also reflecting weaknesses of design and operation), poor infrastructure, and an inability to control care provision to a satisfactory degree.

Contribution rates have been increased by relatively small amounts, thus keeping pace with the general level of wage increases. In 2000, contributions were 2.5% of the employee's earnings, split 50:50 between the employer and the employee. The formula is stepped, in that the premium is the same for all employees within each of five earnings ranges.

The number of ranges was increased to ten in 2001, by splitting the highest range into five parts. Further splits of the higher income ranges are planned for 2002. Even then, however, it could be reasonably claimed that the rates are insufficiently progressive at the upper end.

Covered services are little different from those specified in the Act. Thus they continue to be predominantly for diagnostic and therapeutic services provided on a hospital inpatient basis.

Few people are happy with the current mix of benefits. On the one hand, most types of inpatient care are covered although there is reason to believe that some kinds of treatments are ineffective or otherwise of low value for money. For example, episiorrhaphy and hemorrhiodectomy should probably be excluded in most circumstances. On the other hand, many types of valuable non-inpatient services are not covered at all. Examples include acupuncture for selected conditions and management of child abuse. A related problem is that, by paying benefits for inpatient but not outpatient care, there are perverse incentives to admit. A good example is mental illness: as noted earlier, inpatient care is covered but outpatient care is not.

Another example concerns childbirth. At present, PhilHealth provides inpatient benefits for all high-risk births, but only for the first child if there are low risks. This creates an incentive for care providers to over-state the risks for the second and subsequent births, and is one reason why caesarean section rates are high. In 2000, PhilHealth designed an extension, whereby second and subsequent low-risk births would be covered by a package of antenatal and postnatal services and delivery in what might be termed a birthing centre. This is a facility that usually does not cater for overnight stays and is operated by midwives unless there are sufficient problems to justify the attendance of an obstetrician. Unlike the inpatient benefits for childbirth, there will be no copayments.

This was an excellent idea in isolation, but it created new problems. For example, it meant that second and subsequent births would be supported by antenatal care benefits, but not the first - although they would generally be more beneficial. Thus the package had to be redesigned to take account of its impact on existing insurance benefits. This is one illustration of the risks of evolutionary paths that start from a confused history. Australia's private health insurance has similar weaknesses that originate in accidents of history, such as its focus on inpatient care in private hospitals with separate billing for medical care.

Another serious constraint to re-structuring of benefits is that PhilHealth lacks control over the levels and quality of services that are provided. Thus it is difficult to ensure that (say) if non-inpatient benefits are extended as substitutes for inpatient care, they will in fact be substitutes rather than additions.

Interest in modification of coverage has grown. Most informed observers agree there should be an increase in benefits for preventive and promotive services, pharmaceuticals, and non-hospital services in general (Busse and Schwartz 1997).

There has been less unanimity with respect to any corresponding reduction in the scope of covered inpatient services. Opposition has been particularly strong from those hospitals and doctors who are predominantly involved in inpatient care and who are concerned that they lack the resources to change their practice patterns. They have tended to view the proposals as no more than a cost-cutting exercise, and to believe they are already being poorly paid.

PhilHealth has begun to make progress in spite of the difficulties. Several new benefits packages have been designed and are intended to be activated in the near future. For example, a same-day cataract procedures package has been developed in consultation with care providers that will involve per case payment and no copayments, and which is supported by well-designed clinical practice guidelines. Other new services under consideration or about to be implemented include low-risk childbirth outside hospital (as described above), and ambulatory care for asthma, urinary tract infections, and essential hypertension.

For the most part, payments to care providers continue to be unbundled, as in Medicare I and II (and like private insurer payments to most private hospitals in Australia). There are separate payments for each day of stay, drugs (by broad category), imagings and pathology, operating room services, and medical services. Payments for medical services are based on a procedure classification (the RUV table) that is similar in structure to the Medicare Benefits Schedule in Australia. The table has recently been updated.

Drugs are required to be itemised in full, using generic terminology from a formulary maintained by the Department of Health. PhilHealth is planning to issue a set of indicative prices for drugs, and to move towards restriction of supply to accredited pharmacies that accept price constraints. However, it has no immediate plans for dealing with issues of cost-effectiveness along the lines used in Australia's Pharmaceutical Benefits Scheme. It has, however, identified Australia's approach as a possible model.

It is widely recognised that many care providers are inefficient as a direct consequence of the way they are paid. PhilHealth wishes to move away from itemised bills, but only a few changes have been possible thus far. This is mainly because there has been strong opposition from some care providers who see per case payment as a device for reducing their profitability rather than for increasing the cost-effectiveness of the health care system as a whole. One consequence is that PhilHealth has found it difficult to increase the range and quality of services covered under the Program. Nor has it been able to afford to reduce the level of copayments.

Benefit rates have been increased more or less in line with general price inflation. They vary by level of hospital, and the differences are large. For example, the daily rate for accommodation is almost three times as much in tertiary as in primary hospitals.

Rates also vary by three levels of severity. 'Catastrophic' is defined in terms of injuries and diseases (cancer, AMI, renal failure, etc) and procedures (coronary bypass, neurosurgery, etc) with a total RUV of 20 or more when done in one OR session. 'Intensive' refers to care in an intensive care unit, various specified injuries and diseases, and procedures with complexity exceeding a stated level (measured by the RUV payment weights) when done in one OR session. 'Ordinary' comprises the residual cases.

Problems have been experienced with respect to the auditing of assignment to a severity class. Moreover, there are obvious weaknesses in the structure of the classification. Consideration had been given to introducing a modified version of the DRG classification, but there are practical constraints including the cost that would be incurred in clinical coding.

Benefits for inpatient accommodation are limited to 45 days in any year. There is no carry-over of unused benefits between years. Outpatient services are counted as one inpatient day. Where there are multiple treatments of the same condition, with less than 90 days between episodes, they are treated as a single episode. Thus the benefit ceilings on drugs, imaging, and pathology apply to the multiple treatments.

Little has been achieved with regard to copayments. They were significantly reduced in the first year of operation, in comparison to the Medicare schemes - down from about 70% to 50% of total hospital charges. Since then, they have been relatively stable, in spite of increases in benefit rates. The underlying problem is that PhilHealth has not been able to control total charges. As noted above, hospitals have tended to increase their charges by at least the same amount as the benefit increases.

Thus far, the dominant model has been ceiling copayments: the benefit is fixed, and the patient must pay the remainder of the health care bill above the benefit level. However, there is an important effect of the unbundling of bills. The benefit ceilings are specified for each item of service, and the care providers consistently charge more than the benefit level for each item. This means there is always a copayment, and the model is therefore closer to a proportional than a pure ceiling model.

Figure 4: illustration of the actual copayment model in comparison to three pure models

Seven illustrative hospital bills (P)	A	B	C	D	E	F	G
Total charge for inpatient episode	1656	2147	2798	3549	4550	13351	25195
Patient payments by copayment model							
Proportional (50%)	828	1074	1399	1775	2275	6676	12598
Front-end deductible (P2000)	1656	2000	2000	2000	2000	2000	2000
Ceiling (P10000)	0	0	0	0	0	3351	15195
Actual method (estimated)	994	1181	1483	1810	2230	6008	10078

This is illustrated in Figure 4. PhilHealth has recently moved towards requiring a statement of total charges on care providers' claims forms, but compliance is suspected to be low. The data in Figure 4 are not claimed to be accurate.

The recent introduction of a per case payment model with no copayments is a step in the right direction. However, there is no clear understanding as to the extent that this approach can be expanded, or about the preferred overall level of copayments or their distribution among beneficiaries.

Hospital accreditation methods are under review, and a sensible model is being developed. Progress has been delayed by confusion about the relative roles of the Department of Health and PhilHealth, and about the related functions of licensing, hospital contracting, and auditing.

Claims processing and audit methods have been improved relative to the Medicare schemes. For example, the complexity of claim submissions has been reduced and beneficiaries are no longer expected to pay the hospital in full - and then wait for an unreasonable period of time before receiving reimbursement of the covered amount from PhilHealth. In most cases, patients are required only to make the copayments directly to the care provider. Claims for the covered amounts are sent directly to PhilHealth by the provider and, after review, payments are made directly to the provider. However, there is still too much complexity, mainly as a consequence of weaknesses in PhilHealth's information systems.

Auditing has become clinically more sophisticated. However, it is still a largely manual process, and based on 100% checking (rather than targeted sampling in a way that guarantees errors will be found).

Discussion

PhilHealth has recognised the kinds of problems outlined above, and is taking sensible steps to address them. Development efforts are focussing on six areas at the time of writing.

First, much attention is being paid to ways of establishing greater control over health service delivery, and consequently over costs and quality of care. It will only be possible to build consumer confidence and provide additional value for money to finance new and better benefit packages if service delivery is under control.

The most important step is judged to be that of re-structuring benefits around per case payment based on clinical practice guidelines and costed clinical pathways. This will be done gradually, building on the clinical practice guidelines that already exist - and on the excellent packages that have recently been constructed for cataract procedures and low-risk childbirth. Early action is feasible and highly desirable with respect to the 20 or so case types that account for most of the benefit payments.

The idea of per case payment is not restricted to complete inpatient episodes. The new package for low-risk childbirth illustrates one kind of extension, and the same approach should be applied to many other care needs.

It has been relatively easy to encourage provider acceptance of per case payment for new packages. There will be more difficulty in changing to per case payment for currently covered services because some providers will see this as no more than a cost-cutting exercise. Indeed, they are already lobbying in various ways, and using arguments that are known in other countries - like the danger to quality of care as a consequence of premature discharge.

It is intended that immediate developments in quality of care and outcomes management will be built around the top 20 case types described above. A focus of effort is essential, and pathway-based care is more easily monitored and audited. An instrument for evaluation of pathway-based care is being tested at the time of writing.

Second, there is the need to move towards competitive contracting of care providers. PhilHealth will never have sufficient power to act in the best interests of members until it is able to offer additional patient volumes in return for improvements in cost and quality management. Moreover, a process of appraisal and selection of preferred providers will give members valuable information to help them make their own choice of provider.

There has been little progress thus far, mainly because of concerns over a reduction of choice. Indeed, the arguments are much the same as those that have been directed at Australian private health insurers that have moved towards selective contracting. Thus it is necessary, for example, to ensure that distance to the nearest care provider is not increased to an excessive degree and to ensure members' preferences are taken into account.

On the other hand, it is equally important to ensure that there is sufficient competition between care providers to encourage them to take careful account of patients' rights. The answer is more or less the same in any country: selective contracting must be judged in terms of its effects on value for money for beneficiaries - rather than (say) on whether it causes cost reductions of interest to the insurer or protects the worst care providers from any need to try to improve.

Third, new services need to be added to the set of benefits. PhilHealth has correctly judged that ambulatory services must be the top priority. However, the key is establishment of a routine process of rating of options that makes use of estimates of value for money. The process needs to be objective and transparent if PhilHealth is to be able to make the right decisions - and defend them against groups with vested interests.

At the time of writing, PhilHealth is beginning to make use of estimates of QALYs per Peso. The services rated thus far are those that are of immediate interest including cataract surgery, low-risk childbirth, and 'quit smoking'.

At the same time, the methods of judging value for money need to be applied to some services already included in the benefits package. The intention should be to identify and then remove from coverage at least a few of the low-value services. This is important, if only to give all parties - and particularly beneficiaries and care providers - a clear message about principles and future practice.

Fourth, more attention needs to be paid to the issue of copayments. It was noted above that the common approach is proportional copayment, and this means that many people will have to forgo expensive but high-value services or be bankrupted. A fairer model would be front-end deductibles, but there is the risk of discouraging the use of low-cost and high-value services. For example, the application of an FED copayment for child immunisations would almost certainly be counter-productive. The answer is clear, in general terms: copayments should be designed to maximise overall value for money, but with some degree of concern for equity of distribution of costs and benefits.

Fifth, consideration is being given to creating benefit tiers: that is, offering optional additional benefits for additional premiums. There is a market for these services which is currently poorly met by commercial insurers, and there is the potential for PhilHealth to generate profits that will subsidise improvements in the compulsory basic benefits package.

Sixth, there is growing concern over the slow rate of expansion of coverage. At the time of writing, the government is attempting to activate a national health reform strategy that includes stimulation of insurance. One element termed the Health Passport Initiative is directed at increasing indigent membership by concerted action involving PhilHealth, the Department of Health, and local government authorities. Its main feature is that indigents, once registered, would have access to both NHIP benefits and free or subsidised care financed by the Department of Health and the local government authority. The idea is good, and could serve as a model for the entire population in due course. However, there will need to be greater commitment and collaboration between the parties than has been the case in the past. Like Australian federal and state governments, cost- and blame-shifting are popular pastimes among the various health sector agencies in The Philippines.

Finally, more needs to be done to involve beneficiaries in routine management and strategic decision making. There is one employer and one employee member on the Board of PhilHealth, but no other formal and routine processes exist that allow members to have a say in decisions about the operation of the Program. There is inertia on both the insurer and the care provider sides, and experience from elsewhere has shown that powerful consumer groups are one valuable way of counteracting self-interest, mindless bureaucracy, and a loss of direction.

When planning some of the changes, The Philippines could look to Australia. Indeed, PhilHealth has been taking note of Australia's experiences in the introduction of per case payment and the management of cost-effectiveness in the pharmaceuticals sector.

In other respects, Australia might well look to The Philippines for good ideas. For example, we suspect that it is more cost-effective to have a single health insurer and purchaser in the government sector, and to have that purchaser operate the accreditation process. Australia might also consider using clinical practice guidelines as the basis for illustrative clinical pathways, costed pathways for the determination of benefit payment rates, making the use of suitable pathways a condition of contract, and the structuring of claims audit and quality of care programs around the audit of pathways and variances. Of course, none of these ideas is new to Australia, and they are already being applied in part. It is time they became the norm.

It is unclear which country has the most to learn about optional additional insurance, and its relationship to compulsory and universal insurance. The Philippines has poorly designed links at present, and neither the public nor the private schemes come close to being as effective overall as those in Australia. However, PhilHealth's plans for developing optional health insurance in order to subsidise basic services for all citizens through the universal scheme seem to be socially more acceptable than Australia's moves of late to use funds that might have been applied to Medicare to reward those who wish to obtain more care (and earlier care through queue-jumping) through private insurance.

Both countries are taking an approach that tries to balance equity and privilege, mainly because of its political acceptability. The debate in both countries has strong similarities, and a balance of interests is widely accepted. Unfortunately, there is a tendency to assume that, if a mixed model is pursued, there will be fewer technical and socio-economic problems. We suspect that the reverse is true. The two countries discussed in this paper have a long way to go before the battle between equity and privilege is resolved in a cost-effective way.

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