

Small Applied Research

**Local Governments’
Health Financing
Initiatives: Evaluation,
Synthesis, and
Prospects for the
National Health
Insurance Program in
the Philippines**

June 1999

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Partnerships
for Health
Reform

PHR



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- ▲ *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

The Philippines has pursued a radical program of devolution giving local government prime responsibility for health care. At the same time the National Health Insurance Program (NHIP) aims to expand coverage of health insurance to the poor. This paper examines the allocative and internal efficiency of provincial government-sponsored health insurance programs. The study showed that performances of the two health programs were strongly influenced by the simplicity of administration, proximity of facilities, pricing, innovativeness, skills, and social/political dynamics. The household survey showed that members were from the relatively lower economic classes. This evidence was also cited by the service providers who viewed their participation in the programs as their form of service to the poor. Members were generally satisfied with the benefits offered by the program and appeared willing to pay for higher benefits. There was evidence of relatively higher use rates by members compared to nonmembers. Cost-sharing mechanisms between households and local government units increased the probability of retention and expansion of membership, as supported by the Guimaras Health Insurance Program experience. Relative efficiencies abound, from the relatively lower costs of operation of private and urban services to the shorter processing time of payments due to proximity of the program staff and members. One major constraint of the larger program, the Bukidnon Health Insurance Program, was the large subsidy support provided by the provincial government. Its complex system of benefits and payment to providers created systemic problems more difficult to recognize and solve. The provincial experience can prove useful to the NHIP, especially in the task of financing health care for the indigent or informal sectors. In the absence of a national financing policy on the provincial schemes, the study can assist the decision to integrate provincial schemes into the NHIP as part of a multi-tiered strategy to provide universal coverage. The NHIP may opt to replicate the provincial health insurance models in other areas as an interim strategy towards the achievement of universal health care.

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Acronyms

ASC	Administrative Service Contractor
BHIP	Bukidnon Health Insurance Program
CBHCO	Community-based Health Care Organization
DOH	Department of Health
FIES	Family Income and Expenditures Survey
GHIP	Guimaras Health Insurance Program
GSIS	Government Service and Insurance Corporation
HFD	Health Finance Development
HH	Household
HIP	Health Insurance Program
HMO	Health Maintenance Organization
IRA	Internal Revenue Allotment
IRR	Implementing Rules and Regulations
LGU	Local Government Unit
LHIO	Local Health Insurance Office
MHO	Municipal Health Officers
NHIP	National Health Insurance Program
OWWA	Overseas Workers Welfare Administration
PHIC	Philippine Health Insurance Corporation/PhilHealth
PhP	Philippine Peso
PHR	Partnerships for Health Reform
PMCC	Philippine Medical Care Commission
RHU	Rural Health Unit
SSS	Social Security System
USAID	United States Agency for International Development
WHO	World Health Organization

Exchange Rate

US\$ 1.00 = 40.05 PhP

Foreword

Part of the mission of the Partnerships for Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact.” This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The main objective of the Applied Research program is to prepare and implement an agenda of research that will advance the knowledge about health sector reform at the global and individual country levels.

An important component of PHR’s applied research is the Small Applied Research (SAR) program. SAR grants are awarded, on a competitive basis, to developing-country research institutions, individuals, and nonprofit organizations to study policy-relevant issues in the realm of health sector reform. The SAR program has twin objectives: to provide data and analyses relevant to policy concerns in the researcher’s own country, and to help strengthen the health policy research capacity of developing country organizations. While PHR provides technical advice and support to the SAR grantees, the content and conclusions in the final research reports are the responsibility of the grantees. They do not necessarily reflect the views of USAID or PHR.

A total of 16 small research grants have been awarded to researchers throughout the developing world. Topics studied include health financing strategies, the role of the private sector in health care delivery, and the efficiency of public health facilities.

SAR grant recipients are encouraged to disseminate the findings of their work locally. In addition, final reports of the SAR research studies are available from the PHR Resource Center and via the PHR website. Summaries of study findings are provided through the PHR “in brief” series.

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This study was conducted as part of PHR’s Small Applied Research Program, which seeks to advance knowledge about the advantages and disadvantages of untested health policy initiatives. PHR is sponsored by the United States Agency for International Development (USAID). The opinions expressed herein are of the authors(s) and do not necessarily reflect the views of Abt Associates Inc., prime contractor of PHR, or USAID.

Executive Summary

The Philippine health sector has embarked on two major reform initiatives: decentralization of health services and the establishment of a national health insurance program. These initiatives were developed at different points in time, by different government institutions. Decentralization was initiated by the legislative body of the Philippines, and the National Health Insurance Program (NHIP) was initiated by the Philippine Medical Care Commission-Department of Health, with technical advice from the Health Finance Development Project of the U.S. Agency for International Development.

Decentralization, which was implemented in 1992 through the Devolution Act, transferred health service planning, administration, and control of local health facilities and programs to the provincial, city, and municipal governments. The national government retained control of regional hospitals and public health programs such as immunization and disease control. It is in this spirit that provincial health insurance programs (HIPs) were undertaken.

The NHIP was instituted through the Philippine National Health Insurance Corporation Law, under Republic Act No. 7875 in 1995. The act changed the status and responsibility of the Philippine Medical Care Commission—the agency responsible for the compulsory health insurance program of the employed sector (Medicare)—by turning it into a government corporation called the Philippine Health Insurance Corporation (PHIC) to implement the NHIP. The PHIC is mandated to provide health insurance coverage to 25 percent of the population, especially the poor and the non-formal, within five years, and universal coverage within 15 years. The NHIP has since focused on networking with local governments to implement the program for indigents.

The seemingly opposing tendencies of decentralization and nationalization present unique opportunities to explore health financing and policy reform issues on program design, specifically in targeting low-income groups. Moreover, they allow the exploration of the efficiency of cooperative arrangements between the public and private sectors, administrative and financial sustainability, and other areas.

Stakeholder analyses examined the motivating values, nature of competition, political dynamics, and timing that shape the direction of health financing reforms at the national and provincial levels. The slow pace of reforms, and the unlikely achievement of mandates such as those mentioned, can be explained by the centralizing tendencies of the newly formed corporation, PHIC. Its lack of policy towards local government-initiated health financing schemes reflects a failure to maximize the resources and commitment at local levels to improve health services access. Because of a lack of vision and the political dynamics of the Philippines, the new corporation is failing to maximize a unique opportunity provided by the new law to evolve a more pluralistic health financing regime for the country. The PHIC's strategy of having one indigent program for buy-in by selected municipalities reflects the bias of upper-level management for control, centralization, and administrative simplicity.

The timing of events has created a complex process of change, which has made managing the whole reform process more difficult, especially as stakeholder actions and interests impinge on the conduct of long-term policies. Health professionals in the public sector have been most resistant to devolution. In an attempt not to be caught between local politics and the health hierarchy, the PHIC

presented a totally new scheme for local governments to buy into an indigent program. Rather than devise new schemes to support provincial initiatives, the PHIC's scheme directly manages an indigent program for a municipality or province, retains control over local contributions, and reimburses providers directly. The indigent program can be viewed as one way by which political support from the local officials can be mustered for the national candidates of the ruling party. However, lack of technical capacities, even at means testing, along with the varying political interests and absence of adequate information, continue to challenge the NHIP.

Given the opposing concepts of health service decentralization and health insurance centralization, the challenge now lies in reconciling the differences—in picking the best from each to improve the health of the Philippine population. The two HIPs studied here provide a glimpse of the potentials and limitations of locally managed health financing programs. These HIPs have been able to reach low-income groups as well as those unable to access basic health services because of physical or financial limitations. Improved cost-sharing mechanisms promote wider coverage. Local governments are in the best position to provide counterpart contributions to household premiums for health insurance coverage. Even if the poor appear to be reached, the fact that premiums do not distinguish by income types shows less consciousness of solidarity or cross-subsidization. However, the complexity of the system may tax current management capacities.

For allocative efficiency, provincial HIPs have improved access to private health services. However, without a deliberate design to channel utilization towards appropriate levels, cost pressures will arise. The Bukidnon HIP, with its private providers, has failed to maximize use of the government's primary-level facilities, thereby creating the push for costly secondary- and tertiary-level facilities. In contrast, by using public frontline services as points of recruitment, the Guimaras HIP has been able to maximize its primary levels and therefore contain the push for costly hospital services. The market structure of health services in the country, however, poses difficulties for local initiatives, as gatekeeping efforts are stymied by primary care providers with a direct financial stake as hospital owners.

From a limited technical efficiency perspective, urban and private facilities were shown to be more efficient, able to provide services at lower average prices than rural and public facilities. However, on the whole, operating efficiency in the programs is limited. High subsidy levels due to high utilization appear to be indefensible in the face of the prevalence of low-cost illnesses and declining membership. Inefficiencies can be attributed to ineffective market structures in the physician services market.

Various workshops involving providers and other stakeholders raised the question of how local health financing initiatives and the NHIP can be reconciled to achieve universal health insurance coverage. There is significant interest among Bukidnon HIP providers in exploring an interface with the PHIC, particularly through mechanisms like reinsurance, cross-subsidization, and reimbursement schemes. This arose from an understanding that the PHIC's size offers advantages such as a larger risk-pool, a larger financial base, and a national network of health service providers.

From the local perspective, their involvement in the national program can be justified through the explicit mention in the new law of the following: acknowledgment of their role and existence, especially as community-based health care organizations and local government-initiated programs, and as viable modes for cost-sharing to ensure the fair and equitable sharing of costs among members. The Implementing Rules and Regulations contain guidelines that specify several contracting areas for PHIC, with regards to other health financing schemes. Provincial schemes can serve as administrative service contractors, as health maintenance organizations, or as community-based health care

organizations, with ability to arrange for coverage of designated services to plan members with fixed premiums. The provincial HIPs appear to have capabilities with both contracting schemes.

Stakeholder analyses conducted by this research project show that the HIPs and PHIC have convergent interests in expanding population coverage, enhancing cost-sharing mechanisms, promoting financial self-sufficiency, and pushing for innovation in provider payment, as well as in gaining political support.

This study shows that despite weaknesses in allocative and technical areas, provincial health financing schemes remain a viable option in reaching vulnerable and relatively poor constituents. It is hoped that the analyses and concerns raised in this study can contribute to a better understanding of competence of agents and the markets that flow from their interaction to assist policy towards achieving universal health insurance coverage. Further action can be directed at replicating similar schemes to other areas in the country, with innovations in provider accreditation and payment systems and alternative arrangements in delivery systems. PHIC can address replication by exploring alternative organizational structures that can promote health insurance ventures, issue reinsurance policies, and open a window for a health financing stabilization fund to assist local initiatives. Moreover, further research can examine the institutional aspects of the health system in general, especially the structure of provider markets in the country, as well as the overall strategic planning and management capabilities of local decision makers.

1. Introduction

This report presents the results of a study examining local governments' health financing programs in the Philippines during a period of nationalization under the national health insurance law. The seemingly opposing tendencies of nationalization of health care financing and decentralization of health care service provision, represented by the Philippine National Health Insurance Corporation Law and the Devolution Act, present unique opportunities to explore health financing and policy reform issues on program design, specifically in targeting low-income groups. Moreover, they allow the exploration of the efficiency of cooperative arrangements between the public and private sectors, administrative and financial sustainability, and other areas. These issues were explored through primary and secondary data and strategic analyses. Two provincial health financing schemes were evaluated, identifying both positive and weak program elements and their consequences. Strategic analysis was undertaken to explore issues where local and national programs can interface.

1.1 Background

The Philippine health sector has embarked on two major reform initiatives: decentralization of health services and the establishment of a national health insurance program. These initiatives were developed at different points in time by different government institutions: the first by congressional bodies and the latter by the Philippine Medical Care Commission-Department of Health (PMCC-DOH), with technical advice from the Health Finance Development (HFD) Project of the U.S. Agency for International Development (USAID). Decentralization, which was implemented in 1992 through the Devolution Act, transferred health service planning, administration, and control of local health facilities and programs to the provincial, city, and municipal governments. The national government retained control of regional hospitals and public health programs such as immunization and disease control. Devolution in the health sector was generally viewed to bring about (a) better planning and allocation of resources to reflect local needs; (b) greater efficiency in decision making; and (c) enhanced capacity for service delivery and resource generation through local participation. The National Health Insurance Program (NHIP) was instituted through the Philippine National Health Insurance Corporation Law, under Republic Act No. 787, in 1995.

The newfound autonomy of local governments, after a long period of authoritarian rule and central administrative control, spawned various local health projects, one of which is the highly favored health insurance scheme. The provincial governments of Guimaras and Bukidnon instituted their own provincewide health insurance programs (GHIP and BHIP, respectively). These local government-initiated programs also benefited from the technical advice provided by the HFD project. But these schemes remained administratively autonomous from donor and central agencies. Moreover, their efficiency and equity have not been evaluated, especially in terms of providing basic health coverage and in targeting and protecting the poor and vulnerable.

The NHIP has focused on networking with local governments to implement the program for indigents. The act changed the status and responsibility of the PMCC—the agency responsible for the compulsory health insurance program of the employed sector (Medicare)—by turning it into a government corporation called the Philippine Health Insurance Corporation (PHIC) mandated to implement the NHIP. It consolidated the management of health insurance funds of the public and private sectors away from the social security agencies, namely, the Government Service and

Insurance Corporation (GSIS) and the Social Security System (SSS). Moreover, it has a specific mandate to provide health insurance coverage to 25 percent of the population within five years and universal coverage within 15 years.

Prior to its transformation into PHIC, or PhilHealth, the old Medicare program promoted, through a program called Medicare II, the establishment of community financing programs in a few municipalities. These programs have provided limited health insurance coverage for the local population, combining members' contributions with local government contributions. Small in scope and limited in coverage, these community financing programs no longer exist, except possibly in one municipality. Community financing initiatives in the Philippines, including these big provincial initiatives, are coordinated in an ad-hoc manner, with no clear administrative supervision, utilization reviews, or financial oversight by outside bodies. While PHIC is actively involved in its promotion, these local health financing initiatives are largely "owned," controlled, and managed by local governments. When PHIC embarked on its indigent program, it offered its own package without recognizing existing provincial schemes. How PHIC will relate to these schemes, especially in fulfilling its mandate of a national insurance program, and be a major player and regulator in the health service marketplace remains to be seen.

This research is the first systematic attempt to explore the interface between the local and national health insurance schemes. Through such an analysis, this research can contribute to the timely identification of strategies or processes that link local initiatives and the NHIP. Lastly, this study is expected to contribute to national and international discussions, given the unique opportunity it offers to compare health service decentralization and the NHIP, which although conceived separately, were implemented similarly. Moreover, they are linked by their common objective to provide health insurance to the poor. The lessons learned from this research can guide other countries planning a similar undertaking.

1.2 Research Objectives

This research sought to evaluate the effectiveness of local government-initiated financing schemes developed to provide the population with health insurance coverage. This includes households, communities, local organizations, local officials, and providers. By virtue of program origins and intentions, it can be surmised that local financing initiatives initially set out to reach lower income and vulnerable groups that formal health insurance schemes did not reach. The research examined whether this objective had been achieved and considered the efficiency, cost-effectiveness, and sustainability of these programs. In so doing, the report assessed how these local financing schemes can fit into the design and implementation of the NHIP to facilitate a mutually supportive environment that will promote efficiency, equity, health service quality, and sustainability in the country's health system.

The evaluation will feed into program enhancements that seek to achieve an efficient health insurance program that is comprehensive in scope and national in coverage, and enjoys popular support from local, nonformal groups. Any interface design can only be built from an understanding of public (local and national) fiscal constraints, public management capabilities, provider behavior, and the kind of health behavior the public seeks.

The research addressed the following policy questions:

- ▲ What are the local and national program interests in health financing?

- ▲ Are there similarities and differences in program performance and capacities? How can these interests be reconciled in light of these differences?
- ▲ What is the performance of provincial health financing initiatives in terms of targeting low-income sectors, offering efficiency, equity, financial viability, sustainability, and acceptability, and improving the population's health status?
- ▲ Are the poor targeted and do they benefit from these schemes?

1.3 Methodology and Analysis

The study obtained primary data through field surveys, interviews, and focus group discussions at the provincial level. Guimaras and Bukidnon, the two provinces with health insurance programs, were covered. Secondary data were also used, mainly through provincial fund records and provincial socioeconomic data. The study was structured so that the tasks revolved around the research questions.

The study used a political reform model to examine the political and administrative environment in which the two provincial schemes were undertaken and implemented. A program assessment that detailed administrative and market structure contexts was also discussed. A strategic mapping exercise was undertaken to examine various stakeholder interests and assess strategies for collaboration. Consultative workshops were also undertaken to address interface issues.

The research question involving the performance of provincial financing schemes was analyzed following standard World Health Organization (WHO, 1995) criteria on equity, efficiency, effectiveness, and sustainability of health financing reform initiatives.

1.4 Organization of the Report

The report is divided into two substantive papers. The first paper looks at the macro-level issues of decentralization and provincial-level schemes' interface. It also examines the historical developments in health financing policy reforms and the political-administrative elements of decision making and implementation at the national and provincial levels. This part also presents the results of the strategic mapping exercises undertaken to examine interface issues.

The second paper discusses the results of the study's primary data gathering from households, providers, and insurance records to assess the provincial schemes' performances in terms of the evaluation criteria discussed in detail in the text. It concludes with a summary and further direction for policy action and research.

2. Provincial and National Decision Making and Institutional Aspects of Health Financing Schemes

This section reviews health financing policy developments in the Philippines and examines external policy and administrative environments to determine the prospects of provincial health financing schemes operating jointly or independently of a national health insurance program. It probes policy and administrative behavior in assessing the tensions between local provincial initiatives and the NHIP. It also examines how the two schemes fit together and their strengths and vulnerabilities. A politico-strategic mapping exercise is undertaken to examine stakeholder values, strengths, and weaknesses, as well as policy orientation and policy gaps.

2.1 The Macroeconomic and Health Environments

2.1.1 The Philippine Macroeconomy

The Philippines is an archipelago with over 7,000 islands and 68.6 million people. For the past three decades, fertility rates have outpaced economic growth rates. Therefore, much of the country's problems are poverty related. Table A.1 in Annex A shows some basic indicators. The Philippine economic performance can be described as lurching from periods of recession to periods of growth, thus leaving a stagnating economy. The lack of sustained growth is viewed as one of the major causes of the inability to substantially reduce poverty and of the deteriorating performance in social indicators (Lim, 1998).

Table A.2 in Annex A shows the nature of disparities across regions in the country. According to the latest Family Income and Expenditures Survey (FIES), an estimated 32.1 percent of all households, comprising about 4.5 million families, live below the poverty threshold. The National Capital Region, the main metropolis, had a poverty rate of 7.1 percent, while the newly formed Autonomous Region in Muslim Mindanao had a poverty rate of 58.6 percent. Between 1994 and 1998, the number of poor families in the rural areas increased nearly 10 percent over 1994 levels (NSCB, 1998).

Poor nutrition is prevalent among Filipino children, with 7.5 percent of preschoolers and 6.2 percent of school children being moderately or severely underweight (see Table A.3 in Annex A). Nine out of the 10 leading causes of morbidity, and three out of the 10 leading causes of death, are infectious in nature and preventable, indicating a lack of sanitary living conditions and health services for early treatment (see Table A.4 in Annex A). Diarrhea, a water-borne disease, remains the leading cause of morbidity and the eighth cause of mortality. This indicates the lack of even basic health facilities, such as sanitary toilets and sources of potable water. One out of 10 Filipinos does not have access to safe drinking water. Moreover, more than 60 percent of the population do not use sanitary toilet facilities.

Statistics released in 1998 showed that the single largest occupational group in the country is agricultural workers and fishermen, accounting for 39 percent of the labor force, followed by laborers, who account for 23 percent. Wages and salaries comprised a large proportion (45.2 percent) of total income, while the share of wages and salaries from the agricultural sector decreased from 4 percent to 3 percent between 1994 and 1998.

2.1.2 Socioeconomic Profile of the Provinces

The two provinces of Guimaras and Bukidnon implemented provincial health insurance schemes prior to the national health insurance law. (A location map is included in Figure A.1 of Annex A.) Data for this part of the study were culled from provincial reports and development plans.

2.1.2.1 Guimaras

The province of Guimaras comprises an area of 60,465 hectares and is situated southeast of Panay and northwest of Negros island. It became autonomous from Iloilo in 1992. Guimaras has an estimated population of 130,036, nearly 50 percent of which are 15- to 49-years old. The population growth rate was 3.24 percent in 1993. Guimaras is classified as a fifth-class province, considered one of the poorest in the country.

A data dissemination meeting, held in Guimaras in July 1998, revealed that the labor force participation rate was 55.1 percent in 1990. The unemployment rate was 15.3 percent, with unemployment higher among females (nearly 30 percent) compared with males (10 percent). Agriculture and fisheries are the main sources of income for the majority of the population. The major crops grown are palay (rice), coconut, and mango. Guimaras is developing into a major fruit-producing province. Quarrying is its main industry, along with some fruit-processing activities.

Planning data showed that the income figure being used is still based on the 1991 FIES. Median household income was 10,000 Philippines pesos (PhP). Annual per capita income was PhP6,545, a figure which is more than one-half of the poverty income threshold. More than 75 percent of households were considered poor.

Crude birth and death rates, including infant mortality rates, increased in 1997 over the previous year's figures. Tables A.5 and A.6 in Annex A show the rankings for morbidity and mortality causes in the two provinces as compared with the national ranking. Nine out of the 10 leading causes of disease were infectious and preventable. Illness and death were caused primarily by pneumonia and tuberculosis.

The province has five rural health units and 43 health stations providing primary health care as well as three government hospitals. Five physicians serve as municipal health officers (MHOs), 14 serve as hospital doctors, and about 41 midwives work in the health stations.

2.1.2.2 Bukidnon

Bukidnon is a landlocked province located in the south of the Philippines. It is an extensive plateau in northern Mindanao, covering an area of 829,328 hectares. Nearly a third of the area is used for agriculture, and more than 50 percent is considered forestland.

In the 1995 census, the population of Bukidnon was 940,403. On the average, population grows by 2.2 percent annually. Nearly 44.2 percent of the population is between the ages of 0 to 14, a relatively young group compared to Guimaras' population profile. The labor force participation rate was 80.6 percent, with the majority (77 percent) of the population employed in agriculture and forestry. The second major occupation was elementary education teachers, which comprised 12.4 percent. Income data showed that 27 percent of the families received average annual incomes of PhP25,000. Five percent of families earned an annual income of PhP12,000.

In terms of mortality and morbidity rankings (as shown in Tables A.5 and A.6), both provincial profiles show slight variations from the national patterns. For example, morbidity in Guimaras was related to, among other causes, typhoid, viral hepatitis, and scabies, which most likely reflected poor sanitation systems. Bukidnon's high incidence of schistosomiasis, a parasitic disease, probably indicates the local government did not take adequate preventive measures. None of these causes were ranked nationally.

The health delivery infrastructure in Bukidnon is more diverse than in Guimaras. Bukidnon has 69 private hospitals, covering 76 percent of the municipalities, and six government hospitals. There are 22 rural health units and 464 village health stations manned by 23 doctors, 77 nurses, and 47 midwives.

2.2 Health Policy Developments

This section describes two major health policy initiatives: the devolution of health services and the NHIP. It provides a brief background of the NHIP and the provincial health insurance plans.

2.2.1 Devolution of Health Services

The Philippines began a wide-ranging decentralization program in 1993. The program was viewed not only as a mechanism to arrest the deteriorating fiscal positions, but also as a political move to consolidate the gains made in popular democracy following the ouster of an authoritarian government. It sought to strengthen local governments and wean them away from a strong central government. Through the Local Government Code of 1991, central government delegated funds, power, and responsibilities to local government units (LGUs). The law further stipulated that LGUs would receive an increased share from internal revenues collected by the central government, which would be based on land area, population size, income classification, and some factor of proportionality. Table A.7 in Annex A shows the classification of local authorities by income levels; however, it is the share of local governments in the revenue allocations for devolved functions that remains a major problem.

The devolution of health services led to the transfer of personnel, functions, facilities, assets, and inventories to varying levels of government. Provincial governments received the bulk of services, including 596 provincial, district, and municipal hospitals and 70 provincial health offices. The municipalities were made responsible for primary care centers composed of 2,299 rural health units (RHUs) and 10,683 *barangay* (village) health stations, including staff and inventory. The cities absorbed city health offices, although some cities in metropolitan and charter areas were already responsible for their health systems. In terms of personnel, central DOH personnel consisting of 45,893 technical and administrative personnel were transferred to their local units, representing a 61 percent reduction in staff at the central office.

In an early assessment of the impact of devolution, Capuno and Solon (1996) pointed out the preexisting disparities in the financing positions of LGUs. Despite the fact that provinces absorbed the bulk of devolved functions, the cities received the largest portion of internal revenue allotments (IRA), followed by provinces, then municipalities. In terms of health expenditures, while provinces and municipalities showed marked increases, cities' expenditures declined. While spending for health care rose, these outlays remained covered by augmented budgets. However, the glaring inequities of revenue share and responsibilities remained.

It was within this context of local governments flexing their newfound strength amidst uncertain fiscal conditions that Bukidnon and Guimaras were particularly receptive to offers from the HFD project to pilot test a provincial health insurance program under the Medicare II program of the PMCC, the predecessor to PHIC. In 1993, the HFD project provided technical assistance for the design of the program and consultations. Guimaras established a Medicare II program, a year after its recognition as an autonomous province. In February 1994, Bukidnon established the Bukidnon Health Insurance Program. These two provincial schemes preceded the NHIP by two years.

2.2.2 The National Health Insurance Program

On February 14, 1995, the president of the Philippines signed into law Republic Act 7875, also known as "An Act Instituting the National Health Insurance Program for all Filipinos and Establishing the Philippine Health Insurance Corporation." Specifically, Section 3 of the act identifies the following objectives:

- ▲ Provide all citizens of the Philippines with the mechanism to gain financial access to health services;
- ▲ Create the National Health Insurance Program, to serve as the means to help the people pay for health care services;
- ▲ Prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford such services; and
- ▲ Establish the Philippine Health Insurance Corporation that will administer the Program at the central and local levels.

In April 1996, the PHIC (or PhilHealth) Board approved the Implementing Rules and Regulations (IRR) of the act. These rules provide details on the law such as enrollment guidelines, contributions, benefits packages, payment of claims, national quality assurance, accreditation of providers, administrative remedies, and other procedural rules for the corporation. The rules also contain provisions for policy formulation and review as well as remedial measures to make the implementation more effective and efficient.

The basic principles guiding the law include the following: social solidarity, equity, maximum community participation, and quality of services. PHIC calls its priority goals and strategies "corporate mandates." PHIC upholds the following:

- ▲ Implement the NHIP and provide all Filipinos with access to health care services within 15 years (as contained in R.A. 7875);

- ▲ Cover the poorest 25 percent of the population within five years (as signified in Administrative Order No. 277 signed by President Ramos in June 1996);
- ▲ Expand population coverage before benefits; and
- ▲ Expand benefits, following actuarial studies.

The last two corporate goals signify the importance given to expanded coverage and the maintenance of actuarial-based benefits.

For the past two years, PHIC has been caught up in two major activities. First, it consolidated health insurance funds previously managed by two social security agencies, the GSIS (for public employees) and SSS (for private employees), including the Overseas Workers Welfare Administration (OWWA) contributions to its funds. The basic minimum package of inpatient care, on a reimbursement basis, was retained. Premiums are paid through payroll contributions, equal to 2.5 percent of an employee's salary, which is shared equally with the employer. The contribution cap of 3,000 pesos has remained unchanged since 1993. The status of this consolidated fund is shown in Table A.8 in Annex A.

Second, PHIC went on a support mobilization campaign for its NHIP indigent program in pursuit of its mandate of universal coverage, focusing on the poorest 25 percent of the population by 2001. Under the indigent program, indigent households are identified through a means test. Qualified households are enrolled in the program, which entitles them to benefits similar to those of government employees.

The basic design of the indigent package is as follows. The premium for an indigent household is PhP1,188 per year. The cost of the premiums is divided between the local government units (provincial, city, or municipal government) and the NHIP. For first- to third-class LGUs, 50 percent of the premium is to be paid by the LGU and 50 percent by the NHIP. For fourth- to sixth-class LGUs, which are considered relatively poorer, the NHIP provides a higher counterpart at the beginning and expects to gradually reduce this to 50 percent after the fifth year. In some areas, the provincial government and the municipal governments might decide to share the cost of the LGU counterpart. The status of implementation of the indigent program is shown in Table A.8 in Annex A.

PHIC is currently expanding its organization. It is expected to establish 13 regional offices, known as Local Health Insurance Offices (LHIOs), designed to act as information centers and partners in networking with LGUs in the indigent program. These offices also will be involved in membership registration, preaccreditation inspection, and monitoring, and they are expected to do claims processing. Presently, accreditation and claims processing are done centrally.

2.2.3 Provincial Health Financing Schemes

The Guimaras and Bukidnon provincial health insurance programs were established as part of a program called Medicare II. Medicare II was intended to be a health insurance program for the informal sector and to serve as a counterpart to the program for the formally employed sector catered to by PHIC's predecessor, PMCC. Two decades have passed since the Medicare system began in 1972, and estimates show that only 38 percent of the population have benefited from Medicare, either as principal members or beneficiaries.

Medicare II programs were established in small municipalities and coordinated by the programs office of PMCC, which also monitored program implementation. PMCC provided technical assistance in program design, design of collection and payment systems, policy and guidelines, and other program logistics like identification cards. Local government units implemented the program. Three to four municipal programs already existed when PMCC launched its provincial programs, beginning with Guimaras and Bukidnon, in 1992-1994.

When the National Health Insurance Law was passed, approximately seven municipalities and three provinces were implementing a Medicare II program. Currently, only the original provincial pilot sites, Guimaras and Bukidnon, still have the program. PHIC, which operates the NHIP, does not have a coordinating mechanism in place of the former Medicare II schemes. Essentially, the provincial schemes are on their own. Table 2.1 summarizes the main features of the two provincial programs in relation to NHIP.

Table 2.1 Features of National and Sample Provincial Health Insurance Schemes

Features	NHIP	BHIP	GHIP
Year of Implementation	1995	1994	1993
Initiator of the Scheme	Legislature thru PMCC, in partnership with Dept. of Health (Health Finance Development Project)	PMCC in partnership with Dept. of Health (Health Finance Development Project) (USAID)	PMCC in partnership with Dept. of Health Finance Development Project (USAID)
Implementing Agency	Philippine Health Insurance Corp.	Provincial Government of Bukidnon	Provincial Government of Guimaras
Governing Body	PhilHealth Board	BHIP Advisory Council with the assistance of the Technical Group	Program Coordinating Council with the assistance of the Province Project Office
Membership	All employed and licensed overseas workers, voluntary for self-employed	Voluntary and open to all residents of Bukidnon, renewable yearly	Voluntary and open to all residents of Guimaras, renewable yearly
Premium or Contribution	Contributions based on salary grades with maximum of PhP900 per member /per year (450-450 sharing between employee and employer) to cover up to four dependents	PhP 720 per member per year (including member's dependents), which can be paid annually, semi-annually, or quarterly	PhP 100 per member per year including member's dependents, paid as follows: <ul style="list-style-type: none"> ▲ PhP 60 – paid by the member ▲ PhP 25 – counterpart from the provincial government ▲ PhP 15 – counterpart from the ▲ municipal government
Benefit Package	Hospital admissions with reimbursement ceilings by type of facility to include: room and board, medicines, lab/diagnostics, professional fees, surgery classified by relative unit values, theatre charges	Covered benefits per family per year <ul style="list-style-type: none"> ▲ Service of preferred family physician for outpatient consultation and during hospitalization ▲ Consultation (PhP 30 for Consultation fee and PhP 150 for medicines) 	Covered benefits per family per year <ul style="list-style-type: none"> Free hospitalization for 20 days Inpatient medicines from PhP 500 to PhP 1,500 Inpatient routine laboratory examination 10 percent discount for X-ray and ECG when hospitalized

Features	NHIP	BHIP	GHIP
Year of Implementation	1995	1994	1993
		<ul style="list-style-type: none"> ▲ Outpatient medicines up to PhP 1,500 per family per year that can be availed of during office hours from Monday to Friday except holidays at PhP 130 per patient per consultation ▲ Laboratory and diagnostic services of PhP 500 per family per year ▲ Dental services including consultation and extraction up to PhP 500 per family per year ▲ Hospital expenses up to PhP 5,000 per family per year to cover room and board, medicines, laboratory, and other diagnostic services 	
Providers (as of Aug.'98) 19	Accredited public and private providers (with licensure by the Department of Health as minimum requirement)	37 accredited physicians <ul style="list-style-type: none"> ▲ 14 private physicians ▲ 33 government-employed physicians 23 accredited dentists <ul style="list-style-type: none"> ▲ 13 private dentists ▲ 10 government-employed dentists 	All doctors working in Guimaras Provincial Hospital, GPH-Buenavista Extension and Nueva Valencia Community Hospital (14 physicians)
Provider Payment	Fee for service with set rates; RuV for surgeons	Capitation fee (outpatient dep't) Fee for service of inpatient	No payment to provider

2.2.3.1 The Guimaras Health Insurance Program (GHIP)

Prior to the provincewide health insurance program established in late 1993, Medicare II had a municipal pilot scheme in Nueva Valencia, which started in 1985. This was largely due to the existence of a Medicare hospital, established in the early 1980s by PMCC. However, when the democratic government came to power, about three or four Medicare hospitals were placed under DOH.

With the devolution fully implemented in 1992, Guimaras agreed to enter into a memorandum of agreement with PMCC to implement a provincewide health insurance scheme. The expressed goal of program organizers, which included the provincial government, PMCC through the technical support of the HFD project, and DOH, was to provide access to basic health services. Membership was for household units, and the program was designed for premiums to be paid by households (PhP60), with counterpart contributions from municipal (PhP15) and provincial governments (25), for a total of PhP100 per household. Since the program was tenable only in the province, and the province had no private hospital provider, the benefit package under the plan consisted mainly of medicine or drug reimbursement for inpatient care in the province's hospitals. A specially built Medicare wing in the provincial hospital was funded by program funds.

The plan covers medical benefits such as free hospitalization for 20 days; free medicines from PhP600-PhP1,500; free routine laboratory exams; 10 percent discounts for X-rays and ECGs; and free professional services.

When the program originator, the governor, ran for and won the office of the province's congressional representative, there were doubts as to the plan's continued existence. However, in consultations conducted by this research, the new governor, who is a medical doctor, has expressed support for the program.

2.2.3.2 The Bukidnon Health Insurance Program

The BHIP was implemented in February 1994 after more than a year's planning that started in August 1992. Its objective is to provide residents, particularly those not covered by the regular Medicare program, with access to quality medical and dental health services. It was initiated through a resolution of the provincial legislature, and it developed PMCC and DOH support through the HFD project.

Premiums of PhP720 (approximately PhP2 per day) are charged on a per-family-per-year basis. Plan members are provided with a passbook that details the member's payment and utilization information. One distinguishing feature of the program is it includes outpatient benefits tenable in public and private accredited facilities, which the enrollees choose themselves. Outpatient providers are paid on a per head or capitation basis. Although this feature was eliminated after a few months, capitation was reinstated in early 1999.

The benefit caps are as follows:

- ▲ PhP1,500 per family per year for medicines that can be availed on a per patient per consultation charge limit of PhP180;
- ▲ PhP500 for laboratory and diagnostic services;
- ▲ Dental services of PhP500 per family per year; and
- ▲ Hospital expenses of PhP5,000 per family per year.

2.2.4 Health Policy Development: Summary and Assessment

Health policy development in the Philippines appears to show opposing tendencies. On the one hand, the government undertook a broad-based reform in decentralization or devolution. In general, devolution was meant to reflect a people-power mindset or empowerment that had brought about the transition from a dictatorial regime to a democracy. Devolution in the health sector was generally viewed as a way to bring about better planning and allocation of resources to reflect local needs, greater efficiency in decision making, and enhanced capacity for service delivery and resource generation through local participation. It is in this spirit that provincial health financing initiatives were undertaken.

On the other hand, a wide-ranging health financing reform was put in place to establish a national health insurance program. It led to administrative changes that combined two health insurance funds (public and private employment funds) into a single unified fund managed by one corporation. The transition to the new system has been marked by the centralizing tendencies of

health insurance operations. The large pool of funds managed by the PHIC represents the single largest influence on the health sector, but there is no discernable movement toward policy formulation that would influence the health system. It is in this light that this discussion on the interface of the provincial and national health insurance programs (HIPs) is undertaken.

The interface question is basically one of locating the provincial health insurance schemes in the NHIP. Adapting from Reich (1995), health policy reforms can be examined in terms of motivating values, the nature of competition and political dynamics, and timing. These are largely the political aspects to reform. These three areas are explored in the following paragraphs to illumine stakeholder interests discussed at the end of this section.

2.2.4.1 Motivating Values

Reich showed that the examination of values determines “who gets valued goods” or the distributional consequences. Health financing reforms at the national and provincial levels were undertaken to redress imbalances in access to health services. The provincial health insurance plans, for example, were motivated by the concept of equity and were designed to improve lower income groups’ access to health care. For Guimaras, the explicit objective was to provide adequate, affordable, and accessible medical care services to low-income populations. For Bukidnon, the objective was to provide residents, particularly those not covered by the regular Medicare program, with access to quality medical and dental services.

The NHIP was mandated to cover the poorest 25 percent of citizens by 2001. However, the NHIP’s strategy of having one indigent program for buy-in by selected municipalities reflects the bias of NHIP’s upper-level management for control, centralization, and administrative simplicity.

2.2.4.2 Group Competition and Political Dynamics

Both the national and provincial HIPs were undertaken through legal and administrative processes. The national program passed through the legislative processes of enactment. The provincial programs were covered by memorandum of agreements with the previous Medicare program, and they had provincial legislative support. The passage of these bills can be said to reflect the dynamics of interaction between technocrats and politicians. Technocrats, including one international agency (the USAID), were instrumental in initiating both provincial and national schemes. The process involved consulting various groups, including medical professional groups and hospital associations. These groups were not as strong-willed and vocal in their opposition to these bills (as compared to a pharmaceutical bill, which is the subject of Reich’s treatise), which may be a result of the way in which the contentious issue of provider payments was glossed over.

The politicians, on the other hand, saw the health insurance bills as a means to derive political capital. Their constituents often approach them for dole-outs for hospitalization and medicine needs, and the politicians viewed the schemes as opportunities to systematize these dole-outs.

While the passage of the bills did not pose relative difficulties, the conduct of the IRR of the NHIP highlighted the tensions between previous fund managers (the two social security systems) and the PHIC administrators. The administrators tried to receive political capital from the process by “courting” local governments. This may also be attributed to the timing considerations discussed below. The provincial schemes, on the other hand, were administered relatively smoothly. Staff from other units were seconded and advisory board members were appointed. The dynamics of interaction among staff, advisory members, and other stakeholders are assessed separately below.

2.2.4.3 Timing

Policy reforms are affected by external events, and the timing of these events can determine the opportunities for reform and its achievements. Significant problems in the performances of both the NHIP and provincial health schemes can be traced to fortuitousness. The devolution of health services was implemented three years prior to the establishment of the NHIP law. In turn, the provincial health schemes were established prior to the passage of the NHIP. Questions of interface arise precisely because these schemes, while motivated by the same objectives and reflecting technical and political convergence, were adopted and implemented at different periods. Differences in timing create lags in policy response.

In addition, health professionals were resistant to devolution, which may account for their lukewarm interest in the insurance program, especially in Bukidnon. In fact, they remain among those most resistant to devolution. Seeking not to be caught between local politics and the health hierarchy, PHIC presented a totally new scheme for local governments to buy-in for an indigent program. Rather than devising new schemes to support provincial initiatives, PHIC designed a scheme where it directly managed an indigent program for a municipality or province, retained control over local contributions, and reimbursed providers directly.

The NHIP bill was passed in the middle of the term of the previous administration. There was slightly more than a year left after the IRR. The indigent program can be viewed as one way to gain political support from the local officials for the national candidates of the ruling party. It resulted in a “rush” to sign memorandum of agreements between local officials and the NHIP administrators. However, the long process of means testing and setting up of centralized claims systems stymied program implementation.

Indeed, in the heat of the last presidential campaign, identification cards for the indigent program reportedly became part of campaign paraphernalia in some areas. Despite this, the candidate for whom the PHIC administration was identified failed to win the votes. At local municipal elections, however, there were reports from key informants that the supporters of the provincial HIPs were reelected. The political capital one can make out of health care does not appear to be strong at the national level but can hold sway over average voters in local elections. This appears contrary to Enthoven’s (1994) observation that “few governors or presidents are likely to lose an election because of government-created market failures in health care” (p. 1422). What was apparent by then was the failure of the national government.

After the elections and with the coming of the new administration, providers were emboldened to press for reforms. Complaints from providers in Mindanao of huge backlogs (six months to one year) in payments resulted in two things: (1) it focused public attention on the administration of the NHIP; and (2) it heightened the appreciation of HIPs in the areas. A new leadership was put in place at PHIC. As a result, the DOH is now open to the idea of using health financing to strengthen devolution efforts and effect changes in the health system.

2.2.4.4 Stakeholder Interests

Table 2.2 shows the four main stakeholders in the local HIPs and their interests, namely, politicians/governors/mayors, providers, beneficiaries, and administrators. The second column shows the stakeholders’ potential interests in program benefits or what the program means to them. The third column examines the direction they want to go in, or the reasons they feel a need for change. The fourth column identifies the potential areas of influence for achieving broader societal goals. The last column shows potential problem areas given the current program design.

Table 2.2. Stakeholder Interest Matrix

	Viewpoints	Directions	Potentials	Threats
Governor, Mayors, Politicians	<ul style="list-style-type: none"> ▲ Political support ▲ Counterpart funding 	<ul style="list-style-type: none"> ▲ Further improvements (benefit, level, savings) ▲ Status quo 	<ul style="list-style-type: none"> ▲ Greater cost recovery of public facilities ▲ Lower subsidies 	<ul style="list-style-type: none"> ▲ High costs
Providers	<ul style="list-style-type: none"> ▲ Social work ▲ Cost recovery ▲ More patients 	<ul style="list-style-type: none"> ▲ Higher professional fees ▲ Greater benefits (e.g. medicines) 	<ul style="list-style-type: none"> ▲ Integration ▲ Cost recovery/profit 	<ul style="list-style-type: none"> ▲ Delayed payments ▲ Intervention in practice
Beneficiaries	<ul style="list-style-type: none"> ▲ Greater access esp. medicines ▲ Considered not totally indigent ▲ Reimbursement, if any 	<ul style="list-style-type: none"> ▲ Higher ceilings ▲ Improved benefits ▲ Refund for non-use ▲ Add provider choice ▲ Lower premiums 	<ul style="list-style-type: none"> ▲ Greater responsiveness to needs ▲ Protection vs. rising cost of care 	<ul style="list-style-type: none"> ▲ Poly-pharmacy ▲ Drop-out
Administrators	<ul style="list-style-type: none"> ▲ Career objectives ▲ Job award/recognition ▲ Service 	<ul style="list-style-type: none"> ▲ Program stability ▲ Expanded benefits 	<ul style="list-style-type: none"> ▲ Utilization control ▲ Quality assurance ▲ Motivating providers, LGU's, members 	<ul style="list-style-type: none"> ▲ Political maneuvers ▲ Limited technical capacities ▲ Bureaucracy

This matrix was drawn from the various concerns raised during the interviews. It shows government officials are conscious of the political support they gain from the provincial HIP; however, they are also concerned about the amount of funding required to support the program. Therefore, they tend to seek improvements in program benefits or some savings, and, at the very least, they would be satisfied with the status quo. In particular, there is great interest in enhancing cost recovery at public facilities they oversee, as well as in obtaining lower subsidy levels to the provincial health insurance plans. They consider increasing costs the biggest threat to program sustainability.

Providers view the program as an opportunity to do social work, and they appreciate the program for what it can do to recover costs. This is especially critical in their provision of care to the poor. The program also offers an opportunity to expand their client base and foster provider loyalty. Providers welcome changes in the areas that will strengthen their integrated delivery of care and enhance profits. They worry about delayed claims processing and administrative intervention in their practice.

For beneficiaries, the program provides greater access to health care, particularly medicines. They look forward to reimbursements for expenses they incur on medicines purchased outside of accredited facilities. They also appreciate that they can pay some of the costs of the program so that they are not considered totally indigent. Changes they want to see in the program include higher benefit ceilings, better benefits, some refund for nonutilization, and more provider choices. These

changes are proposed largely to create greater responsiveness to the members' needs and provide them with greater protection against the rising costs of care. The current problem areas may lie with their ability to continue paying the premiums and increasing poly-pharmacy.

The administrators see the program from the perspective of their respective careers, the recognition (particularly from national award bodies), and the service they provide to their province-mates. They want greater program stability, as well as to be able to provide more benefits to members. Problem areas they cite include having no systematic programs in utilization controls and quality assurance. They see greater work efforts directed at motivating stakeholders to become more involved. Threats to the program, from their perspective, include the political maneuvers and their limited technical capacities, as well as increasing bureaucratic responses to problems.

3. Institutional Aspects

This section highlights the institutional aspects of the provincial health plans that affect program performance and directions. The institutional context will also impinge on the plan's ability to engage at the national level. Specifically, the section discusses and assesses the market structure of physician services and the financial and administrative structures underpinning the program. These areas are critical to the interface question since they highlight certain strengths and limitations of provincial schemes that can be addressed by collaboration with the national program.

3.1 Structure of the Market for Physicians' Services

How physicians respond to the HIP's incentive systems will determine the structure of the market for services. Program performance is determined by how physicians behave in response to the payment system for providers. For example, under a capitation payment scheme, physicians paid "per head" or for every "covered member" on the list may have no incentive to seek frequent return visits. Capitation is widely viewed as providing a stark contrast to fee-for-service payment systems where physicians are paid on a per-visit basis. Under the latter, there is no incentive to prevent health service utilization if the effective demanders, the physicians, have a financial stake in ordering more use of services.

In Bukidnon, as elsewhere in the Philippines, physicians are not in stand-alone solo practice. In urban areas, physicians commonly hold practice in a hospital wing. This practice grants physicians admitting privileges to the hospital, but it causes confusion among consumers as to the boundaries between a hospital and a clinic. In rural areas, most doctors practice in hospitals that they also own. Mindanao holds the highest concentration (45 percent) of primary hospitals in the country. Primary hospitals are 6- to 24-bed facilities authorized to render services in medicine, pediatrics, obstetrics, and minor surgery. It is this vertical integration of physician practice that blunts the utilization control effects of capitation. (For outpatient services, physicians are paid on a capitation basis.) Since BHIP also covers medicines and laboratory services, although subject to ceilings, practitioners can sacrifice some of their fees in exchange for greater coverage of medicines and laboratory support. For example, for every visit, members are allowed PhP180 worth of benefits divided as follows: PhP30 for fees and the balance for medicines. When hospitalization is required, fee-for-service operates and the physician-owner can tap the PhP5,000 benefit allowance of the insured members, depending on the nature of the illness.

These largely "mom and pop" operations and the relatively low-cost nature of initial investments make for a wider dispersion of private facilities. This fact promotes the geographic equity of BHIP. The physicians can be considered multiproduct primary care specialists, allowing greater substitutability in supply, and hence, the ability to serve wider markets.

To examine the degree of market concentration, the estimated Herfindahl index was 0.13. This signifies a low concentration market of outpatient services in Bukidnon. The index for 1996 was already an improvement by 0.3 index points over 1994, the year BHIP started. Caution, however, is advised in the interpretation of the index. It does not consider submarkets where concentration may be higher. Since primary and secondary hospitals are not further delineated in the data set, subaggregation at this level may also alter the index of concentration.

This competitive structure may have contributed to lower average costs for outpatient visits from urban and private practitioners in Bukidnon (which is discussed in another paper). However, the presence of vertical integration in physician practice is likely to contribute to higher utilization rates in the BHIP because of cost-shifting practices. The GHIP, on the other hand, relying largely on public inpatient services, appeared to show greater utilization controls and much lower average or unit costs.

3.2 Financial Structure

Figures 3.1A and 3.1B illustrate the flow of funds in the two provincial schemes. The discussion of the two plans differs slightly.

Figure 3.1A. BHIP Fund Management System

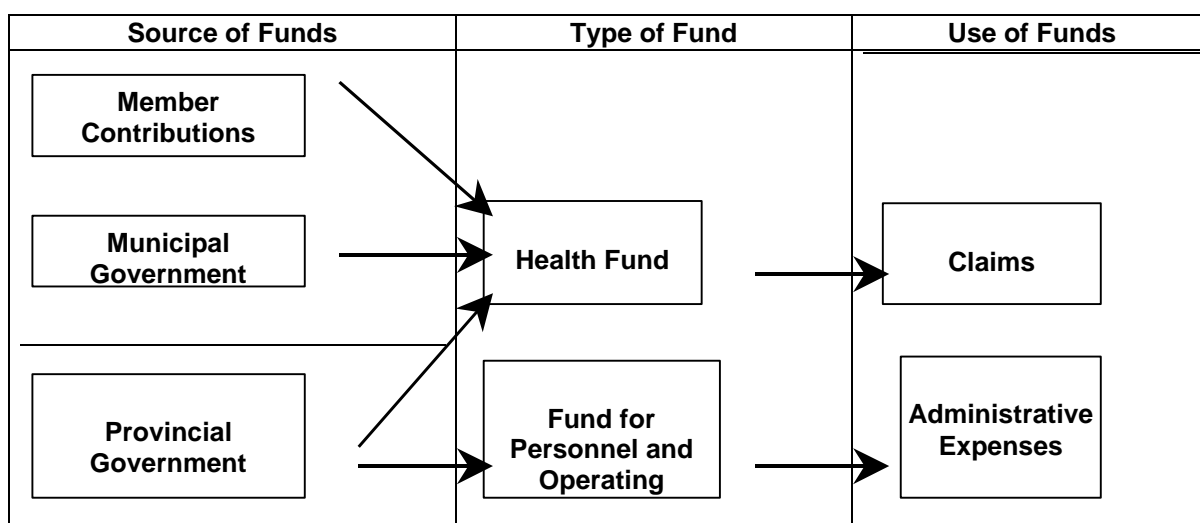
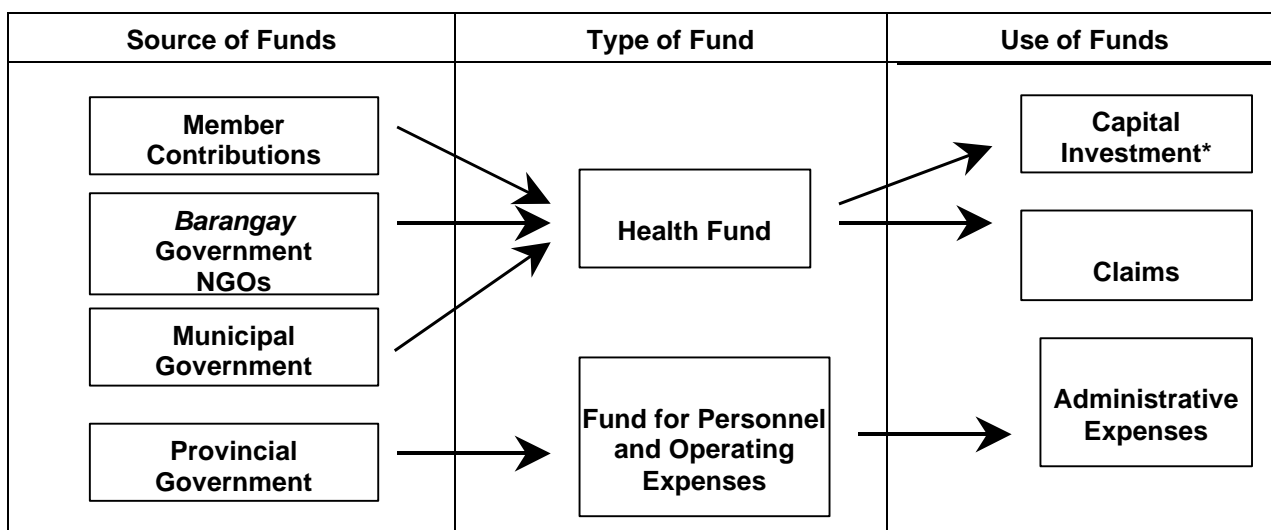


Figure 3.1B. GHIP Fund Management System



BHIP. Member contributions to BHIP are placed in the health fund—a trust fund used exclusively for payment of claims. The BHIP Council and the provincial treasurer’s office manage the fund. Subsidies from the provincial and municipal governments also go directly into the health fund. Personnel seconded from the planning unit manage the health plan, which is headed by an appointed administrator and supported by staff paid from the operations portion of the health insurance fund sourced from the province.

The provincial government also provides funds for administrative expenses. The major advantage of this fund management system lies in the separation of administrative expenses from premium payments used for health service benefits. This separation imposes financial discipline in administrative operations. It also assures the municipal governments that their subsidies go directly into the health fund, thereby ensuring direct benefits to the members. There are, however, problems related to this method, which include the following:

- ▲ LGU appropriations are usually based on historical experience rather than need. (The budget is based on the previous year’s budget.) This feature prevents the LGU from increasing the subsidy along with the membership, making the subsidy the limiting factor.
- ▲ The subsidy levels in the BHIP are, in effect, designed to give maximum support to current members. This becomes a problem because the provincial government maintains the current subsidy level if the membership increases. This makes this subsidy structure not viable when the membership expands. When the membership declines, subsidy levels may remain at the same levels if the incentive structure on claims (as discussed earlier in the physician services organization) is not altered.
- ▲ The separation of the health fund from the fund for administrative expenses makes the evaluation of financial efficiency slightly more difficult for the project implementers. The provincial contributions do not readily appear to form part of the “true” cost of delivering the insurance service. Provincial contributions are also subject to the vagaries of local politics.

GHIP. In Guimaras, the HIP is managed by personnel from the provincial health office and supported by clerks paid from an operating fund managed at the provincial treasurer’s office. Member contributions are placed in the health fund—a trust fund used exclusively to pay claims. The GHIP Council and the provincial treasurer’s office manage the fund. Subsidies from the provincial, municipal, and *barangay* governments also go directly to the health fund. Moreover, the provincial government provides funds for administrative expenses.

The GHIP funds management differs from BHIP in three areas:

- ▲ Villages (*barangays*) are mandated to sponsor the fund by paying full premiums for at least five indigents in the village. Nongovernmental organizations may also pay full premium for identified beneficiaries. This adds to further cost sharing in the provincial HIP.
- ▲ Aside from the payments for members’ claims, GHIP has made a capital investment in the form of a hospital ward for the exclusive use of members. This gives the program greater visibility and may serve to attract further members.
- ▲ The subsidies in GHIP from the provincial, municipal, and *barangay* levels were computed to cover 100 percent of the population, making the subsidy system sustainable even with the expansion of the coverage of the GHIP.

While cost-sharing mechanisms ensure a more viable program in terms of financial support, financial sustainability of the provincial HIPs is likely to depend on operating efficiency or its ability to control utilization and increase premium collections. While the political and financial support of the provincial governments ensures the program's continuity, such support cannot be sustained without improvements in efficiency. The participation of the NHIP in the provincial HIPs should hinge on whether it can improve on this limitation.

3.3 Administrative Capacities

Provincial health insurance schemes largely operate on the basis of support from the constituents through their enrollment. Enrollment is a function not only of household characteristics but also of administrative capacities to recruit new members. Because of relatively high premiums, membership in BHIP is not as broad as that of GHIP. The dropout rates were reported to be high in BHIP. However, the actual figures are not monitored.

Health counselors, who earn a 10 percent commission on premiums, do the recruiting for BHIP. GHIP uses *barangay* health workers (often midwives) for recruitment, who appear to be more motivated.

Both the Bukidnon and Guimaras provincial plans estimate the length of claims processing to be within 45 days from the date of filing. Interviews with providers supported this figure. The area where the provincial HIPs differ from the NHIP is in administrative expenses because the average time for administration claims processing is three to six months.

The records showed that for BHIP, administrative expenses accounted for 17 percent of total expenses and 21 percent of total claims. The staff-to-member ratio is 1:459. GHIP records also showed that administrative expenses comprised 4.3 percent of benefit payments.

Operating efficiency can be enhanced through utilization controls and increased premium collections. The premium collections also could be improved by increased enrollments. Moreover, there are skills and knowledge gaps in social marketing and basic insurance or health financing concepts, and there appears to be a serious lack of financial management skills. For example, a widely held notion among senior administrators is that increasing the membership base will solve the deficit problem for BHIP. However, since at present the program covers only approximately 30 percent of utilization from collections and premiums, it spends more per member than it collects. Thus, an increase in membership would not lessen the subsidy requirements. On the contrary, subsidy levels may even need to be increased.

The BHIP Advisory Council cannot fully function as a venue for feedback from the basic sectors because of the representatives' lack of familiarity with the technical aspects of health insurance. This limited capacity cannot counteract strong professional interests in both provincial and national programs. Physicians are the most articulate members in such a setting.

For GHIP, the pressure points come from the organizational limitations of the project staff. Only one professional, a nurse, provides oversight to the entire program, and the rest of the staff are clerks.

Sustainability entails financial stability and administrative capabilities. Given that the province is unable to increase its budget for the BHIP, benefits in general would have to be reduced. The high level of subsidies for BHIP has made its survival tenuous and highly dependent on the willingness of the political administration to support such subsidy levels.

Among members, there is general satisfaction with the programs but they note a need for more administrative information. For example, no recent market research was done to describe the health financing needs of the different market segments. Variables such as paying capacity, proximity to service providers, and health needs have to be taken into consideration as new benefit packages are designed. The staff and upper-level management will have to gain new skills and knowledge and the organization restructured to effectively respond to the changing needs of the market.

4. Interface Discussion

This section outlines the provincial and national perspectives on the nature of collaboration between the two programs.

4.1 Provincial Perspectives

A consultative workshop involving providers and other stakeholders raised the question of how local health financing initiatives and the NHIP can be reconciled to provide universal health insurance coverage to the Philippines. Most of the input came from Bukidnon providers as Guimaras providers did not have much understanding of the interface question. Guimaras providers do not directly benefit from the provincial program since they are employees of the provincial hospital and are not paid fees.

There is significant interest among providers of the BHIP in exploring an interface with the PHIC, particularly through mechanisms like reinsurance, cross-subsidization, and reimbursement schemes (see Table 4.1). In terms of premiums, the proposal is directed at matching the level of resources available for the NHIP with the local HIP through some cross-subsidization. This will entail keeping some of the formal, or employed sector, funds managed by PHIC within the province.

The BHIP benefit package was seen as clearly superior to the present national program because it includes outpatient benefits. The large risk pool of the national program, however, covers all ailments, with no exclusion for pre-existing illnesses. The proposal is for PHIC to give provinces some leeway in the design of their programs, with the NHIP specifying some minimum benefit package. An area for PHIC's involvement with the provincial HIP will be a reinsurance mechanism for catastrophic diseases. The provincial plan can insure with the PHIC for catastrophic illnesses.

The PHIC's accreditation system was viewed as too restrictive. The single benefit provided—inpatient services—fails to maximize the referral system. Primary physicians are not able to charge for admissions unless they have admitting and consulting arrangements with a hospital. The idea of strengthening the referral system entails differential payments by type of provider.

The passbook system appears to be popular at the local level. Hence, there was a proposal for its adoption at the NHIP level. The passbook details the member's family information, membership status, and utilization levels, with each benefit ceiling specified. It is a vivid representation of a deposit-withdraw mentality that seems to be useful for providers, beneficiaries, and administrators alike. This system also can increase utilization as long as there are still "amounts of benefits" to be drawn.

Table 4.1 Provincial Perspective on Interface

Areas of Concern	Present PhilHealth (NHIP)	Present (BHIP)	Proposed PhilHealth
Premiums	<ul style="list-style-type: none"> ▲ Counterparted by employers ▲ Higher 	<ul style="list-style-type: none"> ▲ Usually the member shoulders premium solely ▲ Lower, affordable 	<ul style="list-style-type: none"> ▲ Provide subsidies ▲ SSS/GSIS contributions from members in the province should remain in the province
Benefit Package	<ul style="list-style-type: none"> ▲ Inpatient only ▲ Portable ▲ No exclusion for pre-existing ▲ Payment per episode 	<ul style="list-style-type: none"> ▲ Outpatient with ceilings ▲ Inpatient-top-off PhilHealth, with ceilings ▲ Limited to the province only ▲ With exclusion of pre-existing 	<ul style="list-style-type: none"> ▲ Provinces can design their own package according to the needs of the people ▲ Should include both outpatient and inpatient package ▲ PhilHealth (national) should insure for catastrophic cases ▲ Create a minimum standard benefit package that is acceptable to all
Accreditation of Providers	<ul style="list-style-type: none"> ▲ Restrictive ▲ Weak referral system 	<ul style="list-style-type: none"> ▲ Improved capacity to deliver better than PhilHealth 	<ul style="list-style-type: none"> ▲ Strengthen the referral system to the present national scheme
Administrative Functions	<ul style="list-style-type: none"> ▲ At present, centralized, no passbook used, slower and longer processing period 	<ul style="list-style-type: none"> ▲ Within the province uses a passbook that is helpful and informative to patients, faster and shorter processing period services through an existing referral system 	<ul style="list-style-type: none"> ▲ Use a passbook or an acceptable identification card where patients will be informed about benefits, especially if ceilings are set
Monitoring of Providers	<ul style="list-style-type: none"> ▲ Strict: fault-finding ▲ Not too frequent 	<ul style="list-style-type: none"> ▲ More frequent and regular ▲ An opportunity to explain oneself ▲ Accessible and open to discussion 	<ul style="list-style-type: none"> ▲ Monitoring should be done on a local level and should use more appropriate tools and parameters
Payment to Providers	<ul style="list-style-type: none"> ▲ Higher 	<ul style="list-style-type: none"> ▲ Only up to maximum limits, lower than PhilHealth 	<ul style="list-style-type: none"> ▲ Maintain payment scheme similar to the present national scheme

In the discussion, providers singled out the importance of face-to-face interaction in the monitoring of service delivery by an insurance program. The monitoring parameters can be identified at the local levels, with general agreement or buy-in from providers. The providers resent the fault-finding attitude of the national program administrators and value the personal and accessible manner of monitoring by local administrators.

Providers also want to have compensation for their services to be on par with the national program, since that would reflect a higher reimbursement.

4.2 National Perspectives

PHIC presently has no systems in place, other than its indigent program, to locate local provincial and other community initiatives in its planning and administrative set-up. However, certain areas where local provincial initiatives can play a role can be identified vis-à-vis the mandate and the IRR of the National Health Insurance Act, Republic Act 7875. This can be used to start PHIC's thinking on the matter.

At the level of the declaration of principles, local government schemes or community schemes can justify their involvement in the national program in four areas:

- ▲ On the principle of innovation, there is explicit recognition of the roles and strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations (CBHCOs).
- ▲ On the principle of devolution, the program was designed to be implemented in consultation with LGUs, subject to the overall policy directions set by the national government.
- ▲ The principle of maximum community participation recognizes the need to build on existing community initiatives for its organization and human resource requirements.
- ▲ On the principle of cost sharing, the program seeks to continuously evaluate its cost-sharing schedule to ensure the costs borne by the members are fair and equitable and that charges of health care providers are reasonable.

In the administration section of the act, referring to the establishment of the LHIO, its powers and functions are specified as follows: to tap community-based volunteer health workers and *barangay* officials, if necessary, for member recruitment, premium collection, and similar activities, and to grant such workers incentives according to the guidelines set by the corporation.

The IRR contain guidelines that specify several contracting areas for PHIC. The first refers to an administrative service contractor (ASC), specified to undertake administrative tasks in relation to the implementation of the program, such as, but not limited to, the conduct of means test, enrollment, and collection of premiums. The ASC can receive contributions from self-employed members by issuing receipts provided by PHIC. The ASC is also mandated to submit weekly reports to the LHIO that include the enrollment list, payment of members, application form, proof of payment, and PHIC receipts.

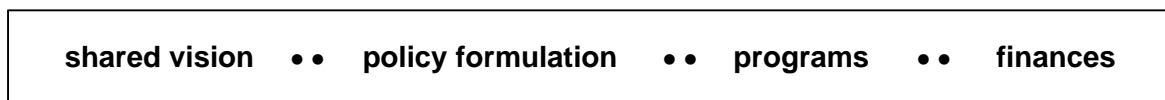
Another area that can be explored by provincial schemes is whether to be contracted as a health maintenance organization (HMO) or CBHCO. An HMO is defined as an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium. The CBHCOs are defined as associations of indigenous members of the community organized to improve the health status of that community through preventive, promotive, and curative health services. There are several guidelines on the accreditation of HMOs and CBHCOs specifying official recognition by other bodies, like the DOH or the Securities and Exchange Commission. They also have minimum requirements regarding facilities and quality assurance, financial capability and stability, and other areas.

The provincial HIPs have two options—be accredited either as an ASC or as an HMO/CBHCO. For the latter, they need to have legal recognition as such. The provincial schemes at present appear to be capable of becoming an ASC. However, it is a diminution of its roles, especially its policy and planning capacities. BHIP, for example, was able to implement a capitation payment scheme and expand benefits to include outpatient services. As an ASC, it would end up as a mere administrative extension of the PHIC. It does not build on the capacities of provincial governments willing to share in the risks.

4.3 Reconciling Both Perspectives

In a consultative meeting attended by PHIC, DOH, legislative and provincial representatives, and other government agencies, the discussion centered on the lack of coordination between the provincial initiatives and the PHIC. Confronting the interface question by identifying mechanisms was viewed as premature, given the absence of PHIC consciousness and policy-level discussions on the matter. The group agreed that, at best, what could be identified was a process of interface. After considering the priority of steps to be taken, the process could be visualized, and it is presented in Figure 4.1.

Figure 4.1 Process of Interface



The process of interfaces starts with an understanding of a shared vision. This exercise can clarify what would be a viable vehicle for interface. For example, one vehicle could be a replication of the current provincial schemes or one of partnership arrangement involving common areas of endeavor. The policy formulation process is expected to follow the shared vision exercise, and it would start with a review of the IRR.

During the discussion, individual groups were able to identify some areas for programmatic collaboration, which should follow policy formulation. It was pointed out, for example, that there should be mechanisms for the sharing of common information prerequisites and models for ready adaptation to suit various provincial needs. Both PHIC and provincial HIPs can also conduct data-collection exercises to give feedback to the policy and management processes. Financial support was another area identified for collaboration, and it includes the need to look into financing arrangements that will improve the funds' mix, particularly those of the provincial HIPs. Interestingly, the group cited financial interface as the penultimate of the interface between programs. It highlights the notion that once funds are committed and mixed, then the NHIP, working with provincial schemes, can be viewed as unified. It is also an acknowledgment of the difficult tasks ahead before unification can occur.

5. Policy Gaps and Recommendations

The new political administration augurs well for reform opportunities. Recent developments show that local governments are embracing health insurance schemes. While PHIC has no policy guidelines in place, the pressures are overwhelming for interface discussion.

Structural deficiencies and management weaknesses remain the biggest stumbling blocks in crafting long-term policies with LGUs and in having effective implementation strategies. There appears to be an inability to manage the various stakeholders' actions and interests, as well as a lack of national authority to set priorities and develop health financing capabilities. Presently there is a general lack of planning systems, limited ability to implement programs, weak systems support, and lack of timely reporting of data critical for internal decision making.

Table 5.1 shows that the HIP and PHIC have convergent interests in expanding population coverage, enhancing cost-sharing mechanisms, promoting financial self-sufficiency, and pushing for innovation in provider payment, as well as in gaining political support.

The areas of divergence are related to politics and financial control. Both programs lack an appreciation of the potential impact of enhancing market competence and policy mediation.

Table 5.1 Interest Gaps Matrix

	PHIC's Interest	Not PHIC's Interest
Provincial HIP's Interest	<ul style="list-style-type: none"> ▲ Population coverage ▲ Cost sharing ▲ Financial self-sufficiency ▲ Alternative payment to providers ▲ Political gains 	<ul style="list-style-type: none"> ▲ Local politics ▲ Functional devolution ▲ Local resource mobilization
Not Provincial HIP's Interest	<ul style="list-style-type: none"> ▲ 100% coverage in 15 years ▲ Centralized financial controls ▲ National resource mobilization 	<ul style="list-style-type: none"> ▲ Market competence ▲ Policy mediation

Moreover, the provincial HIPs have shown that they present viable venues for covering the nonformal, self-employed sector. A common strategic approach for both provincial and national HIPs can enhance access by broadening the number of participants in the health insurance market, with equity considerations based on ability to pay and risk sharing (see Table 5.2).

The lack of group coverage even among cooperatives or nongovernment groups in BHIP has led to adverse selection problems. GHIP, despite having a household base, has adopted a village-level strategy that sought *barangays*, or villages, to subsidize members. Thus, government subsidies in Bukidnon could flow to villages that could provide some counterpart funding support, which would lead to greater participation of the neediest residents.

Table 5.2 Managing the Market

Rational	Key Result Areas	Provincial HFS	PhilHealth
Enhancing Access	<ul style="list-style-type: none"> ▲ Population coverage ▲ Solidarity 	<ul style="list-style-type: none"> ▲ Nonformal, self-employed ▲ Flat rate 	<ul style="list-style-type: none"> ▲ Formal, self-employed ▲ Salary scale
Transforming Agency	<ul style="list-style-type: none"> ▲ Efficient utilization ▲ Provider payment ▲ Entry and exit mechanisms 	<ul style="list-style-type: none"> ▲ Capitation ▲ Selective, local reputation, suspension 	<ul style="list-style-type: none"> ▲ Adjudication ▲ Fee for service ▲ Minimum requirement, legal processes
Transforming Agency	<ul style="list-style-type: none"> ▲ Quality assurance ▲ Composition of policy boards 	<ul style="list-style-type: none"> ▲ Complaints 	<ul style="list-style-type: none"> ▲ Institutionalized ▲ Agency representation
Improving Coordination	<ul style="list-style-type: none"> ▲ Information and education ▲ Cost sharing 	<ul style="list-style-type: none"> ▲ Referral ▲ Multiple financing sources 	<ul style="list-style-type: none"> ▲ Info system

While the passbook system may be popular to members, both members and providers still need to be educated on the proper utilization of benefits. An agency relationship can be fostered between providers and members as well as among members, providers, and administrators. A gatekeeping system also should be fully explored through the appropriate use of the public health’s referral system.

Moreover, quality assurance programs covering both providers and insurance administrators can enhance the market engagement of the provincial systems. Activities can cover areas that streamline processes and lead to agreements on standards of good practice, protocols for case management, and activities directed at greater standardization of practice to improve quality and lessen uncertainties.

The participation of LGUs at the PHIC board can also facilitate a close coordination between the provincial health financing schemes and the national program. Advisory council boards at the local levels need more dynamic representation. Moreover, they should be acquainted with broad societal and macroeconomic perspectives, as well as with technical capacities to manage and transform sectoral objectives into societal goals.

Bringing together the various agents in the market to lower friction in transactions and to address policy and market distortions can improve the level of coordination. This will require greater information and education campaigns, not only to recruit members but also to promote better utilization of benefits. Improving the referral system and strengthening the primary care base of the system also can enhance utilization.

Information, access, and feedback are all critical to coordination. The provincial and national HIPs need to invest in information systems to monitor utilization and membership, and they need to have a profile for providers. Financial records also need to be systematized. Inadequate information on costs, quality, and particularly on health outcomes limit insurers’ ability to influence the health care market. With limited local funds, these needs are likely to be undertaken on a project basis.

Another area identified as lacking some attention from both provincial and national HIPs is mediating to achieve the goals of the national health policy, particularly those of devolution. GHIP has demonstrated that local government networks can be used for cost-sharing mechanisms,

recruitment, information, and education of members. This has sustained the program even with upper-level administrative changes. PHIC has chosen to sidestep the devolution issue by offering a centrally managed program for indigents.

Bukidnon's weak referral system largely stemmed from the difficulties of coordinating many first-contact primary centers managed by the municipalities with the provincial HIP managed by the province. Preserving and strengthening the public health system remains a big challenge for BHIP, especially amidst vertical integration of private health care services.

The viability of the private health care system is one area with which government bodies do not appear to be concerned. Yet this is the system people prefer, and it appears to be more cost-efficient. The private sector's responsiveness to the market, in terms of location and investment decisions, can be harnessed by the insurance systems.

One municipality in Quezon province on the main island, Luzon, also had a Medicare II program, but the loss of its mayor, who ran for a higher post in the May 1998 elections has instilled doubts in the program's viability. Communication problems have prevented any confirmation of the

The PhilHealth program for the regularly employed has a premium of only PhP450 per year per employee. However, this amount is supplemented by a contribution from employers, with a maximum limit of PhP150 per employee per month.

6. Evaluation of Provincial Health Insurance Schemes

6.1 Data Collection and Sources

Data for the evaluation of provincial health insurance schemes were gathered from interviews with households and providers, as well as from insurance records. The household interviews were conducted using a questionnaire designed to collect information on family socioeconomic characteristics, health seeking behavior, insurance plan utilization (for members), and the household's attitudes and perceptions on the insurance programs.

6.1.1 Household Data

The household survey was conducted using multistage sampling techniques. First, the choice of the municipality was determined in terms of the number of accredited providers or health facilities and the number of enrollees in the area. The second criterion in choosing the *barangays*, or villages, was their distance from the provider: near, center, or far. From the *barangay* level, the first household interviewed was a plan member. Succeeding interviews were conducted in two to three houses surrounding this member's residence. Because of the thin density in most rural areas, interviewers were instructed to choose households in a concentric manner in varying distances to the health centers, if the linear two-home distance could not be followed.

The maximum number of households to be covered was proscribed by budget and time considerations; thus there is no attempt to claim that the sample is representative. Any generalization, however, will be valid for plan member households, which were randomly selected from purposively chosen municipalities. Insights from the nonmember and former member samples should be considered as indicative. There is also no attempt made to link the households to specific providers. It is possible for a household to be within a reasonable distance of one accredited provider but registered with another.

For logistical reasons, the new municipalities in Guimaras were not covered, but in Bukidnon, the survey covered 25 percent of municipalities (six out of 21). (See Figure A.1 in Annex A for the location of the study sites.) Tables 6.1 and 6.2 show the number of households interviewed in each province and the membership profile. A total of 85 households were interviewed, 57 of which are plan members, 16 nonmembers, and some 12 lapsed members (those unable to renew membership). The size of plan member households comprised less than 3 percent and 1 percent of the 1998 household enrollees for Bukidnon and Guimaras, respectively. More households were interviewed in Bukidnon than in Guimaras because of their respective population sizes. However, in terms of actual program coverage, Bukidnon, with a larger target population, had a smaller plan enrollment than Guimaras. The GHIP covers almost 25 percent of the province's population while the BHIP barely covers 5 percent of the population.

Table 6.1 Number and Membership Distribution of Household Respondents

Area	Number of households	%	No. of Individuals	%
Bukidnon	61	72%	332	71%
Guimaras	24	28%	134	29%
Total	85	100%	466	100%

Source: Household Survey

Table 6.2 Membership Profile

Area	Members	%	Nonmembers	%	Lapsed	%
Bukidnon	39	68%	11	69%	11	92%
Guimaras	18	32%	5	31%	1	8%
Total	57	100%	16	100%	12	100%

Source: Household Survey

6.1.2 Provider Data

Data on providers were obtained through face-to-face interviews. A structured interview was conducted using a mix of open-ended and multiple choice questions covering items on professional background, conditions of practice, membership in the provincial plans, and perceptions of program implementation. The respondent' names were chosen randomly from a list of providers ordered alphabetically and arranged by municipality.

The questionnaire was pretested with six accredited respondents (four doctors and a dentist from Bukidnon and a doctor from Guimaras). The questions seeking the opinion of the respondents on methods of provider compensation in a collective financing scheme, the manner of coverage of the scheme, and the ideal financing system were deleted. The pretest showed that most of the respondents, despite being part of the provincial and national schemes, had very limited knowledge and understanding of collective arrangements in health care financing. The assessment of performance of administrative and insurance functions did not seem relevant since most of the accredited providers had assistants and clerks who performed these tasks for them. Questions on membership to professional societies were also deleted as they all fulfilled the minimum requirements for the practice of the profession.

Tables 6.3 and 6.4 show the coverage of the provider survey. A total of 29 interviews were conducted: 21 in Bukidnon and eight in Guimaras. The Bukidnon interviews covered 50 percent of the private accredited doctors, 35 percent of accredited public doctors, and 9 percent of accredited dentists. Four nonaccredited providers—two dentists and two doctors—were also interviewed. Physicians accredited in the provincial health insurance plan comprised 21 percent of the total physician population in the province. The accreditation for dentists, on the other hand, covered 27 percent of the dentist population of the province. In Guimaras, where there are only a handful of private practitioners, the eight interviews covered 36 percent of hospital doctors and 60 percent of municipal doctors. The rest of the hospital doctors were specialists who were not directly involved in insurance interactions.

Table 6.3 Number and Membership Distribution of Provider Respondents

	Number of Providers	% of Total in Province
Bukidnon	21	11%
Guimaras	8	42%
Total	29	

Table 6.4 Distribution by Affiliation

Provider	BHIP				GHIP	
	Accredited		Nonaccredited		Accredited	MHO
	Private	Public	Private	Public		
Physician	1	8	1	1	5	3
Dentist	7	1	1	1	-na-	-na-
Total	8	9	2	2	5	3

6.2 Insurance Records

Financial and membership records of both BHIP and GHIP are computerized. The database contains records of members, residences, dependents, and premiums paid, excluding billing and discharge summaries. Medical records remain with the providers. The expense books for claims are computerized but not integrated with members' records. In Bukidnon, records of outpatient and inpatient utilization are shown in patients' cards or passbooks, which the members keep. Members' records are generally reliable but not updated, and financial records showed inconsistencies. Part of the problem with the records is their accessibility due to frequent power breakdowns and systems failures. Information from monthly and annual reports that staff prepared supplemented data sources.

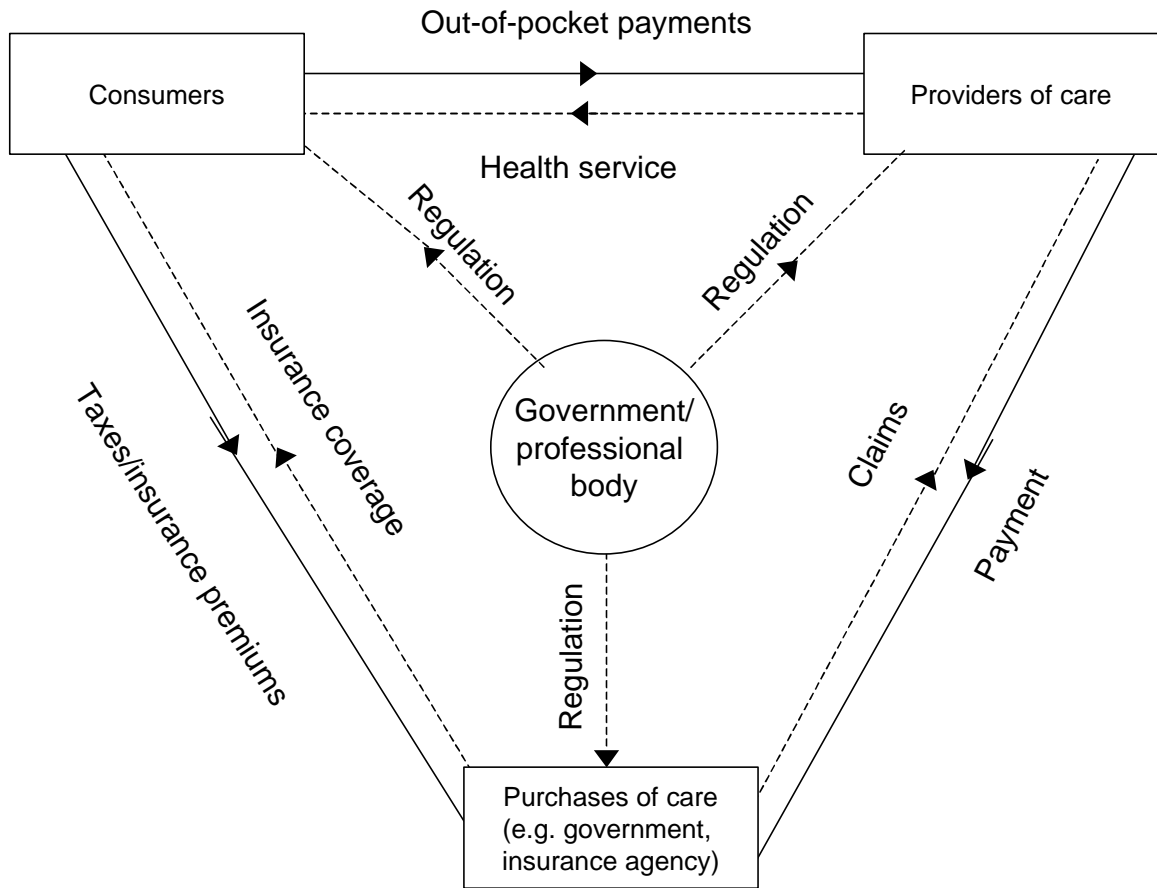
7. Evaluation Framework and Criteria

Health financing systems, whether local or national, public or private, are mechanisms for allocating resources. From a health system's perspective, health insurance schemes mediate between consumers of care and their providers, often forming a tripartite financing arrangement (see Figure 7.1). Health insurance systems purchase care for consumers with providers making claims from the funds' pool generated by insurance agencies from various sources.

The criteria used to examine the performance of the provincial HIPs apply the standard evaluation framework suggested by WHO (1993 and 1995). The criteria are applied according to society's perspective. The overall goal of provincial health insurance schemes is to improve access to basic health care services for the disadvantaged. Therefore, program performance can be assessed in terms of the efficiency, equity, and sustainability of the program in approaching this goal. The criteria applied in this study and their definitions, as adapted from McPake (1995), are identified as follows:

- ▲ Equity—Equity refers to the way the allocative process distributes the gains or benefits and costs of the program. The distribution may vary in terms of financial and physical access or utilization. Equity can be viewed as vertical or horizontal. Vertical equity in health care implies that those with greater needs receive more services than those with less. Horizontal equity suggests that persons with the same need receive the same services.
- ▲ Allocative Efficiency—Resources are allocated to activities that have the highest value or to what may be considered of value. From the insurer's perspective, the pattern of expenditure spending indicates efficiency to the extent that improvements can be made through reallocation. From the consumer's perspective, allocative efficiency means the production of output best satisfies what consumers or clients want.
- ▲ Technical Efficiency—Maximum output is gained from the given inputs. Alternatively, the outputs are produced at minimum cost.
- ▲ Institutional Sustainability—Institutional sustainability is the viability of the program to sustain its momentum and to meet the changes that will be needed for the long haul. This is often linked to program acceptability and management capabilities. Whether the program can exist without subsidies also attests to its institutional stability.
- ▲ Health Impact—Changes in health status may result from the increased access to care provided by the program.

Figure 7.1 Tripartite Financing Arrangements for Health Care



8. Results

This section discusses key items in the interview protocols that provide basic information on household and provider samples. The first part offers an overview of survey information, and the second focuses on insurance membership information. A more summative evaluation of the provincial HIPs is undertaken in the next section.

8.1 Household Profile

8.1.1 Demographic and Socioeconomic Background

Table 8.1 presents some basic information on the sample respondent households. Bukidnon householders were generally younger than Guimaras by at least four years. Household size in Guimaras was slightly larger than in Bukidnon. The households surveyed in Bukidnon were fairly well represented across educational levels. Slightly one-third of Bukidnon household heads reported having at least an elementary education, and another 30 percent reported completing high school. In Guimaras, a larger proportion, 50 percent, of household heads reported having an elementary education.

Bukidnon samples appeared to be well distributed in terms of income. Dividing the population into five income groups, a larger cluster of families (28 percent) reported household incomes in the highest income bracket, followed by 23 percent of families in the second highest income bracket. Guimaras households, however, were concentrated in the bottom income brackets, with 46 percent of families reporting household earnings below 3,000 pesos. Another one-fourth of families reported belonging to the next lowest income group.

In terms of the work status of household heads, the largest group in Bukidnon worked in agricultural/farming, with 46 percent of household heads reporting farming as their primary source of income. In Guimaras, the majority (29 percent) of respondents reported casual work, with no regular income sources for household heads.

One can conclude from the information on worker status of household heads and total household income that farming households in Bukidnon were relatively well-off compared with their counterparts in Guimaras. Farming households in Bukidnon had better access to other income opportunities, thus raising their overall household incomes. Guimaras appeared to offer fewer opportunities for other income, which led to relatively lower household incomes reported. This kind of economic environment reflected in the survey confirms the overall status of the two provinces: Guimaras is one of the poorest provinces in the country, and Bukidnon is relatively well-off.

8.1.2 Health Status and Health Service Utilization

The health status of the provinces, which is reflected by the presence or absence of outpatient consultations conducted in the last month and/or inpatient admissions during the past year, can be gleaned from the sample data. Table 8.2 shows that Guimaras households appeared to be less healthy

as a larger proportion (88 percent) of households reported consultations in the past month than did households in Bukidnon (43 percent). The data from Guimaras reflect the relatively poor living conditions prevailing in the province.

In terms of hospitalization during the past year, the sample appeared to be equally divided, with slightly more households reporting confinement than nonconfinement. In Guimaras, a majority of households (54 percent) did not have a member hospitalized during the past year.

Table 8.1 Demographic and Socioeconomic Background of Sample Households

	Bukidnon		Guimaras	
1. Mean Age, Household (HH) Head	40.7		44.3	
2. Avg. Household Size	5.2		6.8	
3. Educational Level of HH Heads				
	No. of HH	Percent	No. of HH	Percent
Under 6 years	5	8.2	3	12.5
Completed elementary school	18	29.5	9	37.5
High school	7	11.5	2	8.3
Completed high school	18	29.5	6	25.0
Some college	2	3.3	0	0
College and beyond	10	16.4	3	12.5
Vocational	1	1.6	1	4.2
Total	61	100.0	24	100.0
4. Total Household Income				
Less than 3,000 pesos	8	13.1	11	45.8
3,000-4,000	12	19.7	6	25
5,000-7,999	10	16.4	4	16.7
8,000-10,999	14	23.0	1	4.2
11,000 and above	17	27.9	2	8.3
Total	61	100.0	24	100.0
5. Employment, Household Heads				
Permanent	13	21.3	5	20.8
Casual	3	4.9	7	29.2
Farmers	28	45.9	6	25.0
Self-employed	17	27.9	6	25.0
Total	61	100.0	24	100.0

Source: Household Survey

Table 8.2 Health Status and Health Service Utilization, All Household Samples

	Bukidnon		Guimaras	
	No.	%	No.	%
1. Did anyone in the household consult a health professional during past month?				
Yes	29	42.6	16	87.5
No	32	57.3	8	12.5
Total	61	100	24	100
2. Was anyone in the household confined in hospital during past year?				
Yes	31	50.8	11	45.8
No	30	49.2	13	54.2
Total	61	100	24	100

Survey: Household Survey

8.2 Providers' Profile

8.2.1 Demographics and Specialization

A profile of providers shows that most respondents were 31- to 45-years old. The mean age of doctors in Guimaras is 36 (approximately 10 years out of medical school), while private doctors accredited in Bukidnon have an average age of 47 years. Nonaccredited Bukidnon providers have a mean age of 44. The age of physicians may be a critical factor in a capitated system, with older physicians able to attract more clients than younger doctors. Of the total number of physicians accredited in Bukidnon, 47 percent have been in practice 11 to 25 years, while 29 percent have had more than 26 years of practice.

The majority (68 percent) of respondents were female and 11 percent were male. In Bukidnon, female doctors comprised 73 percent of total accredited providers. In Guimaras, the public hospital system was male-dominated, with women comprising only about 36 percent of the physicians.

Among the accredited providers, 76 percent were general practitioners and 24 percent were specialists in various fields (anesthesia, pediatrics, family medicine, and orthopedics). Most of the four nonaccredited providers (75 percent) were general practitioners. The eight municipal health officers (MHOs) interviewed were general practitioners.

8.2.2 Conditions of Practice

In terms of the volume of patients seen for outpatient services, 67 percent of accredited providers reported seeing an average of 50 patients per day. Estimates of the proportion covered by the provincial HIPs ranged from 10 to 20 percent. In Guimaras, most of the providers interviewed saw an average of 60 patients per day in outpatient clinics. About 50 percent of these were reported to be members of the GHIP.

The number of inpatient cases for Bukidnon and Guimaras providers ranged from five to 10 cases per week. It was estimated that 5 to 10 percent were members of the provincial schemes.

The two most common illnesses diagnosed by accredited and nonaccredited providers were upper respiratory tract infections and acute gastroenteritis. Specialists reported cases usually related to their own specialties such as trauma and surgical cases.

For inpatient cases, the two most common reasons for confinement were bronchopneumonia and dehydration secondary to acute gastroenteritis. Most of the inpatient cases had an average length of stay of two to three days. Many of the providers responded that the length of confinement depended on the severity of illness.

9. Program Assessment

9.1 Equity

The overall objective of the provincial health plans is to promote the affordability of basic health services, with special emphasis on reaching the poor. Equity considerations cannot be readily gleaned from insurance records, making monitoring of this aspect largely anecdotal from the program implementer's side. The extent to which the programs have been able to advance the goal of equity can best be examined through the results of the household and provider surveys.

Table 9.1 is a further aggregation of Table 8.1, with household profile distinguished by insurance status. There appears to be no distinguishing demographic characteristic for BHIP membership.

Table 9.1 Demographic and Socioeconomic Profile by Membership Status

	Bukidnon			Guimaras		
	Members	Non-Members	Lapsed Members	Members	Non-Members	Lapsed Members
1. Mean Age, HH Head	41	40	40	48	31	46
2. Avg. HH Size	5	6	5	6	4	8
3. Education of HH Head						
Under 6 years	2 (5.1)	2 (18.2)	1 (9.1)	3 (16.7)	0	0
Completed elementary	10 (25.6)	5 (45.5)	3 (27.3)	7 (38.9)	1 (20.0)	1 (100.0)
High school	6 (15.4)	0 (0.0)	1 (9.1)	1 (5.6)	1 (20.0)	0
Completed high school	13 (33.3)	1 (9.1)	4 (46.4)	5 (27.8)	1 (20.0)	0
Vocational	0 (0.0)	1 (9.1)	0 (0.0)	0 (0.0)	1 (20.0)	0
College	8 (20.5)	2 (18.2)	2 (18.2)	2 (11.1)	1 (20.0)	0
	39 (100.0)	11 (100.0)	11 (100.0)	18 (100.0)	5 (100.0)	1 (100.0)
4. Household Income						
Less than 3,000 pesos	4 (10.3)	3 (27.3)	1 (9.1)	9 (50.0)	1 (25.0)	0 (0.0)
3,000 – 4,999	8 (20.5)	1 (9.1)	3 (27.3)	4 (22.2)	2 (50.0)	0 (0.0)
5,000 – 7,999	9 (23.1)	1 (9.1)	0 (0.0)	3 (16.7)	0 (0.0)	1 (100.0)
8,000 – 10,999	7 (17.9)	3 (27.3)	4 (36.4)	0 (0.0)	1 (25.0)	0 (0.0)
11,000 and up	11 (28.2)	3 (27.3)	3 (27.3)	2 (11.1)	0 (0.0)	0 (0.0)
	39 (100.0)	11 (100.0)	11 (100.0)	18 (100.0)	4 (100.0)	1 (100.0)
5. Employment, Household Head						
Permanent	9 (23.1)	3 (27.3)	1 (9.1)	4 (22.2)	1 (20.0)	0 (0.0)
Casual	1 (2.6)	1 (9.1)	1 (9.1)	5 (27.8)	2 (40.0)	0 (0.0)
Farmers	18 (46.2)	5 (45.5)	5 (45.5)	3 (16.7)	2 (40.0)	1 (100.0)
Self-employed	11 (28.2)	2 (18.2)	4 (36.4)	6 (33.3)	0 (0.0)	0 (0.0)
	39 (100.0)	11 (100.0)	11 (100.0)	18 (100.0)	5 (100.0)	1 (100.0)

() Number in parentheses is percentage
Reference: Household survey

Member and nonmember household heads in Bukidnon appeared to be in the middle age range, and the size of their household was moderate. The majority of member household heads have completed high school, with a fifth reporting some college education. Member households appear to be relatively well distributed across income groups than other household types. About 50 percent of nonmember households reported incomes in the top two brackets compared with 46 percent in the same income brackets for BHIP members. The majority of BHIP members and nonmembers reported farming as their primary economic activity. However, permanent workers was the next largest group for nonmembers, whereas for BHIP, self-employed workers was the next largest group. BHIP therefore appears to have reached households with some ability to pay, but these households would not be regular payers in more formal arrangements because of income seasonality. This has important implications for the design of premium collection arrangements for the provincial health finance scheme.

GHIP appeared to cover older principals (48 as a mean age), with slightly larger families, lower educational levels, and lower incomes, largely sourced from self-employed and casual work arrangements.

9.1.1 Accessibility

The profile of the members in the two plans reflects the socioeconomic status of the provinces. Bukidnon has a richer, more diverse economy than Guimaras, which is considered among the poorest in the country. However, being a vast province, Bukidnon is prone to experiencing greater problems with physical accessibility of health facilities. The mean distance in terms of time to reach facilities in Bukidnon is 41 minutes. This is nearly double the average time (24 minutes) in which Guimaras' respondents can reach providers. Travel time, however, reflects not only physical distance but also the availability and efficiency of transportation systems. The travel time estimates reported were for actual travel and excluded waiting time, which may be hours or even a half-day.

Table 9.2 explores whether there is some relationship between physical distance to the nearest provider and the socioeconomic position of the households. Data from Bukidnon illustrate that time distance to a provider diminishes as income rises. Low-income households in Bukidnon traveled twice as long as the higher income households in Bukidnon. Guimaras data indicated no clear relationship between distance traveled and income of households.

Examining physical accessibility to health facilities by occupation status could provide information valuable to efforts to target health services to lower-income families. In terms of occupation, Bukidnon self-employed families, which reported the lowest average income, appeared to be living farthest from health facilities, followed by farmer groups. Casually employed household heads lived closest to health facilities. Health insurance schemes may often neglect this group of workers as they are considered to be well-off in terms of health service accessibility, but in terms of income, they may not be relatively well-off. In Guimaras, farmer groups reported the lowest income, and the travel time for these groups was reported to be the longest.

**Table 9.2 Physical Accessibility of Plan Members to Providers
(Travel Time to Provider, in Minutes)**

	Bukidnon		Guimaras	
Mean Distance, Minutes	41		24	
1. By Income Levels				
Less than 5,000 pesos	51		16	
5,000 pesos and above	24		15	
2. By Occupation Status of Household Head				
	Avg. Income	Minutes	Avg. Income	Minutes
Permanent	Pesos7,300	25	9,750	13
Casual	5,000	15	2,670	18
Self-employed	4,752	43	2,880	12
Farmer	9,324	28	1,733	25
3. By Length of Membership				
	Minutes		Minutes	
Less than 2 years	12		15	
2 – 3 years	41		15	
More than 3 years	48		18	

Source: Household Survey

The physical accessibility of members, delineated by length of membership with HIPs, shows an interesting trend. In Bukidnon, those who have been with HIPs for the past three to four years appear to have the least physical access to facilities. This may reflect the initial thrust of program administrators to reach out to more isolated areas, albeit to those with some ability to pay. That these members have maintained membership despite the distance of facilities reflects their general satisfaction with the program; they have found it valuable enough to maintain their membership for three to four years. New members are increasingly being drawn from areas closer to health facilities.

In Guimaras, long-term members have only a slight edge in time distance than newer members. Because the study used a relatively small sample size, further aggregation does not allow statistical tests conducted to confirm the significance of the differences in results between the provinces.

9.1.2 Utilization

Table 9.3 is a disaggregation of Table 8.2, to reflect insurance status of households. The data for former or lapsed insurance members are no longer shown due to small numbers. To provide a bit of background on members, average income is shown. Only slight differences were observed in mean income reported by households who are HIP members compared with nonmembers. In Bukidnon, nonmembers reported slightly higher average incomes, while the opposite was observed in Guimaras. Nonmembers of GHIP were shown to have lower incomes, on average, than member households. This makes affordability still an issue in Guimaras despite lower premiums.

It is expected that households with insurance are more likely to respond to illness by seeking professional help than those without insurance. Health service utilization in Bukidnon shows that member respondents have higher outpatient utilization rates (56 percent of households) compared with the 36.4 percent rate for nonmembers.

The trend for Guimaras in outpatient utilization reflects the health status of the population rather than its insurance status. GHIP does not cover outpatient consultation. Nearly all member households interviewed in the survey reported an outpatient consultation during the previous month. Since these services are not included in the Guimaras plan, one can only surmise that the island has greater health needs.

Expenditures per outpatient visits were higher for members than nonmembers. These expenditures included transportation, fees, medicines, diagnostics, and other expenses incurred, without taking into account insurance coverage. It is possible that either transport costs were higher for members or members were sicker than nonmembers, such that they incurred higher expenditures per visit, but it is also likely that billing for fees and medicines was higher for members. Since balance billing is allowed, that is, patients pay for amounts over and beyond those paid by insurance, differences in expenditures may be traced to this.

Table 9.3 Health Service Utilization of Plan Members and Nonmembers

	Bukidnon		Guimaras	
	Members	Nonmembers	Members	Nonmembers
1. Avg. Household Income	PhP 8,185	PhP 8,607	PhP 4,714	PhP 4,020
2. Outpatient Consultations, Past Month				
No. of Household Reporting	22	4	17	4
No. of Individuals	30	4	18	8
No. of Visits Reported	30	6	19	12
No. of HH/Total HH Sample	56.4	36.4	94.4	80.0
No. of Individuals Per HH	0.8	0.4	1	1.6
No. of Visits Per HH	0.8	0.5	1.1	2.4
Avg. Expenditure Per Visit	PhP 338	PhP 194	PhP 259	PhP 115
3. Hospitalization, Past Year				
No. of Households Reporting	24	3	11	0
No. of Individuals	30	3	14	0
No. of Confinement Reported	34	3	16	0
No. of HH/Total HH Sample	61.5	27.3	61.1	--
No. of Individuals Per HH	0.8	0.3	0.8	--
No. of Visits Per HH	0.8	0.3	0.9	--
Avg. Expenditure Per Confin't	PhP 2,965	PhP 2,166	PhP 3,536	--
Percent Paid by HIP	74		12.4	--
Avg. Length of Stay, Days	3.5	3.3	7.2 (10.4)	--

Source: Household Survey

() number includes 3 cases of catastrophic confinements

In terms of inpatient confinements, a higher proportion of member households reported being confined to a hospital than nonmembers. In fact, in Bukidnon, more households reported confinement episodes for the past year than outpatient visits. This is a rather disturbing trend as it shows that the inclusion of outpatient visits has not minimized the need for hospital confinements for members. However, one could not discount the possibility of errors in the interviewees' responses. Hospitalization may be such a traumatic experience that households tend to magnify the experience and report it as having occurred within the year even if the episode may have occurred later. Based on the principal author's assessment, hospital confinement rates in the 60s can be comparable to industry records of health maintenance organizations.

The proportion of households reporting inpatient episodes was nearly the same for Guimaras and Bukidnon. Higher average costs of confinement for Guimaras tend to support the earlier contention that Guimaras' populace may be sicker or they incur higher cost illnesses. It is unfortunate, though, that support from GHIP was only slightly above 10 percent of average costs incurred. The support value from insurance was higher for BHIP at 74 percent of average expenses incurred. It is noted, however, that not all hospital expenses for members were charged to BHIP. There were 10 percent of households who reported being covered by Medicare (the program for formal employees) for their confinement.

Length of hospital stay was twice as long for GHIP members than BHIP members. However, the length of stay for nonmembers in Bukidnon was nearly the same as members. There appears to be a relatively homogenous health profile in Bukidnon. The 10.4 days length of stay in Guimaras is nearly comparable to the 11 percent reported for civil servants in provincial hospitals using a small-scale sample (Bennett and Tangcharoensathien, 1993). Bukidnon's length of stay appears lower compared with data cited by the authors (Ibid.)

9.1.3 Plan Usage

A further examination of the plan members' utilization of their insurance benefits is shown in Table 9.4. The passbook system for BHIP allows easy tracking of outpatient visits, as their passbook reflects the number of times they have used their benefits. Interviewers however counted the number of visits only from the beginning of 1998. For inpatient confinements, households were asked how many times they have used their inpatient benefits since they became members. It was expected that households would have easier recall of this experience since it is not a usual occurrence. The question referring to this utilization or availment of benefits should be distinguished from the earlier health service utilization questions as the former refers to an actual count of the number of times they have used their benefits. The latter question simply referred to whether they had use of health services during the reference period and not necessarily as an insurance benefit.

Table 9.4 Plan Usage by Member Households (Average number of times, per household)

	Use of Outpatient Services, within Year, Bukidnon	Inpatient Confinements Since Membership	
		Bukidnon	Guimaras
1. By Income Group			
Less than 5,000 pesos	3.8	2.9	0.6
5,000 and above	2.9	1.8	1.7
2. By Worker Status, HH Head			
Permanent	4.6	1.3	2.0
Casual	1.0	0	1.0
Self-employed	2.2	2.2	1.7
Farmer	3.4	2.8	0.7
3. By Length of Membership			
Less than 2 years	2.3	2.3	1.0
2 years and more	4.3	4.3	1.1

Source: Household Survey

The household survey showed that the lowest income group in Bukidnon reported more outpatient visits and inpatient confinements, on average, than the relatively higher income group. This reflects a performance indicator for the HIPs; that is, they were able to realize more benefits for poorer members, who were likely to be poorer in health. The use of inpatient benefits was higher for Bukidnon than Guimaras, especially for the poorer members. There could be some barriers that could prevent poorer GHIP members from using the benefits. It is possible that because of low support value, families still have to show they have some other means of paying for their confinements. Hence, there may be delays in seeking care for poorer members, which can be confirmed by the longer lengths of stay, as well as by higher average expenses for confinement. In terms of the upper income group's usage of inpatient benefits, the trend was nearly the same for the two provincial plans.

By occupational group, the permanent worker groups in Bukidnon reported the highest use of outpatient benefits, followed by the farmer groups. It should be noted that these two groups had relatively higher average incomes. In terms of inpatient benefits, farmer groups reported the highest usage, followed by the self-employed groups in Bukidnon. In Guimaras, permanent workers used their inpatient benefits more than other groups. Farmers, the least well-off in Guimaras, utilized their inpatient benefits least.

Those who have been with the program for at least two years reported a lower number of consultations—an average of 2.3 times—compared with those who have been in the program longer. The latter group had an average of four outpatient visits per year.

9.1.4 Financing

Premiums, as a proportion of mean provincial incomes, comprised 1.2 percent for Bukidnon and less than 1 percent for Guimaras. BHIP may have attracted relatively well-off members because its premium is comparatively higher than GHIP's. The proportion of income paid to insurance membership is about 34 percent of average medical care expenditures per family as reported in the 1997 FIES data. The fact that premiums do not vary by income may indicate that social solidarity does not appear to be a major program concern. The two programs do not employ means test, implying that there is no targeting for the lower income groups. Neither was there any barrier to participation for the relatively well-off or the worst off. The household data showed that membership appears well distributed across income levels.

GHIP premiums appear to be affordable to the populace, made possible in part by the 40 percent subsidies from municipal and provincial governments. Yet, the majority of nonmembers replied that the GHIP premiums remain unaffordable.

In terms of the proportion of medical expenses covered by the program, low premiums may translate into lower benefits received. For example, the GHIP maximum hospitalization benefit is capped at PhP 1,500 for each hospital admission per household. The mean hospital expense reported from the survey was PhP 3,536, which is 2.3 times the maximum pay-out allowed by insurance. Thus, households resort to borrowing from relatives and neighbors to cover the shortfall in insurance pay-outs.

9.1.5 Providers' Perspective

The equity goal, particularly that of serving the poor, was the primary reason for the participation of 50 percent of the provider respondents in the program. At the same time, they saw the scheme as an opportunity to earn something; those that were normally treated as charity cases could now be covered by insurance.

In assessing the provincial HIP members, more than half (65 percent) of the providers interviewed in Bukidnon believed that members of the program belong to a different income class from their nonmember patients. They also believed that of their BHIP clients, 60 percent may be considered poor (those earning less than PhP6,000), 30 percent are middle class (living on a public teacher's average monthly salary of PhP6,000), and 10 percent may be regarded as rich (earning more than 6,000 a month).

9.2 Allocative Efficiency

Production can be deemed inefficient if "reallocation" can still be made for everyone's benefit. In a health insurance scheme, spending patterns by funders and consumers determine what these groups consider valuable. However, what they consider valuable may not necessarily be efficient from society's perspective if distortions in the health care system are created or maintained. Unlike technical efficiency, allocative efficiency can indicate more concrete areas where reallocation can be undertaken not simply on the basis of costs, but also on what is appropriate, vis-à-vis needs and best practices.

9.2.1 Public-Private Choices

Table 9.5 indicates that Bukidnon households have a clear preference for outpatient services from private facilities, whether in clinics or hospitals. The opposite is true in Guimaras, where outpatient care was largely sought from public hospital facilities given the dearth of private facilities in the area. In Guimaras, private hospital and public regional admissions accounted for referrals to the main island of Iloilo.

Table 9.5 Provider Choice

	Outpatient				Inpatient			
	Bukidnon		Guimaras		Bukidnon		Guimaras	
	#	%	#	%	#	%	#	%
Private clinic	20	49	6	20	1	2.7		
Private hospital	19	46			32	85.5	1	7.7
Health center			4	13				
Public hospital	2	5	20	66	4	10.8	12	92.3

Reference: Household Survey

* It should be noted that GHIP does not pay for outpatient consultations.

Bukidnon's health insurance records also confirmed this pattern of choice. Bukidnon has five public hospitals scattered across the province, but they are largely ill equipped. Insurance records showed that only 1 percent of patients were capitated for outpatient service in public facilities and 99 percent go to private facilities. Health insurance, therefore, has increased accessibility to private providers.

The fact that the sample in Bukidnon did not report using any lower level public facilities (health centers and health units) reflects the weak referral system in the BHIP, as well as the nonmaximization of the public health system network. This allocative inefficiency may be explained by two factors. First, public health officials initially opposed the devolution program. BHIP, identified as a provincial scheme, had difficulty initially in integrating the health system similar to the predevolution set-up due to the differing loyalties of health workers. Primary care physicians and workers were also devolved to varying levels of local governments. Second, the referral system in the private sector is practically nonexistence. Patients can self-refer, and accredited primary care physicians may also be specialists and hospital owners. The market structure is such that primary physician practice is often integrated with hospital ownership and/or affiliation.

The BHIP's major accomplishment was its innovation in provider payment and the coverage of outpatient benefits in the basic package. Despite the prevalence of fee-for-service payment elsewhere in the financing system, members adjusted quite well to the need to be capitated to a primary provider. For the majority (56 percent) of members, their current provider was not their usual source of care. The difference in accessibility was negligible (from 48 minutes for the previous usual source of care to 47 minutes to the current provider). A provider's characteristics—approachable, reliable, and active—greatly affected the member's choice. Other reasons cited for choosing providers were the following:

- ▲ Usual provider (21 percent of respondents);
- ▲ Recommended/advised by health counselor (17 percent);

- ▲ Own hospital/complete facilities/specialist (15 percent); and
- ▲ No other choice/only provider in the area (15 percent of respondents).

9.2.2 Primary vs. Tertiary

As Table 9.5 indicates, for outpatient visits, the first level of contact is not adequately used. Primary care in the public system is provided in the health center and the rural health unit. In Guimaras, where the public system prevails, there was a fair use of health centers but the majority of the population goes to the public hospital to queue in the outpatients' department. Health center use in Bukidnon was nonexistent. Only 18 percent of MHOs, those who managed the health centers, were accredited by BHIP.

The pattern of morbidity could be ably supported at the primary level. BHIP was not able to maximize this linkage with primary health services. This may reflect the limitations of the devolution process. Provincial governments are responsible for hospital facilities, while municipal governments take care of primary-level health services. The provincial government of Bukidnon, as elsewhere, was unable to integrate primary frontline services with the tertiary facilities in a referral system.

9.2.3 Urban vs. Rural

In the provinces, the urban-rural dichotomy is not readily apparent since all the areas appear to be rural from the perspective of metropolitans. Official distinctions are often made with political boundaries in mind. A more meaningful measure would be in the context of population density. The group identified urban areas to be major town centers and those outside and/or without major town centers as rural. Table 9.6 presents the distribution of providers from Bukidnon's HIP records. There appears to be some imbalance between provider distribution and membership. With only two major urban centers in Bukidnon, rural population exceeded urban population. There were more accredited doctors in rural areas than in urban areas. The distribution of enrollee coverage showed the opposite trend: 54 percent of enrollees were from urban areas compared with 46 percent from rural areas. This could signify that rural families prefer to receive care from urban providers.

Table 9.6 Distribution of Accredited Providers and Members, Urban-Rural, 1996

	No. of Municipalities	Population	No. of Accredited Providers	Ratio of Providers Per Population	Providers Per Municipality	No. of Members
Urban	2	254,142	7	1:36,306	3.50	12,518
Rural	20	758,145	17	1:42,832	0.82	10,901
Total	22	982,287	24	40,929		23,419

Source: BHIP records

9.2.4 Expenditure Patterns

Table 9.7 shows the distribution of benefits used by members according to insurance records. As expected, there were nearly eight times more outpatient services and dental patients served compared with those hospitalized. But as shown in the Expenditures' Share column, expenditures for hospitalizations comprised 50 percent of all program expenditures.

Table 9.7 Bukidnon Benefits vs. Expenditures Shares, Four-Year Average

	Beneficiaries Served (%)	Expenditures' Share (%)
Outpatient	76.5	41.1
Inpatient	10.6	50.7
Dental	10.7	7.43
Lab	2.13	0.74
Total	100.00	100.00

Source: BHIP Records

That hospitalization is expensive is not surprising and may point to three things: (1) a higher level of specialist care needed; (2) the nature of illnesses that require admission; and (3) the effectiveness of gatekeeping. Most of the accredited physicians (86 percent) are engaged in general practice. From the provider interviews, the most common reasons for admissions were bronchopneumonia and acute gastroenteritis. Hospitalization could have been avoided if cases were seen earlier and the health insurance would have eased on the access barrier. Further examination of health-seeking behavior for outpatient visits needs to be made before conclusions can be reached. Gatekeeping practices can also provide additional insights. However, as discussed in the context paper, there are problems with gatekeeping when the gatekeepers themselves have financial interests in the next level of care, especially as hospital owners.

In practice, GHIP's basic benefits package covers medicines only. The program does not pay for professional fees since it uses public hospital facilities. Considering that public facilities usually run out of medicines and other supplies, the supplemental budget provided by the medicine reimbursement from GHIP enhances public hospitals' effectiveness.

Neither of the provincial HIPs keep separate records of the extent of reimbursements for medicines. For BHIP, it can be surmised that payment for medicines is extensive since on a per consultation basis, the PhP150 allowance can cover 87 percent of the cost of standard medicines for common ailments (like cough or flu). Given the structure of the physician market in the provinces (and for the rest of the country), this could lead to irrational patterns of prescription and drug use.

9.3 Technical Efficiency

Meeting program objectives at the least cost indicates an efficient provision of benefits. The lower the costs per given output, the more efficient the provision. Because this survey did not include unit cost of services, however, the analysis will be limited. Nevertheless, the average cost of services may indicate the incentives system prevailing in the insurance programs. This discussion uses insurance records because they reflect trends better than the smaller sample-based, primary-gathered data. Any discrepancies may be due to sampling errors.

9.3.1 Average Costs

Using BHIP insurance records, Table 9.8 highlights two aspects of the outpatient service provision. As Table 9.5 indicated, outpatient service users in Bukidnon prefer private providers since they appear to offer services at costs lower than public providers. The latter charged higher rates against the fund despite having a small number of patients on their lists. The average cost per outpatient for public facilities was nearly 9 percent higher than the average cost per outpatient in private facilities. This relative inefficiency at public facilities may reflect the presence of cost shifting from the insured to noninsured or it may indicate that cases in public facilities are more severe than in private facilities.

Table 9.8 Outpatient Service Costs—Distribution of Patient Load and Receipts, by Type of Provider, 1996

Provider	Patients	% Total	Receipts	% Total	Avg. Cost Per OPD Visit
Private	44,539	99%	6,311,249	99%	141.7016
Public	556	1%	85,538	1%	153.8458
Total	45,095	100%	6,396,787	100%	

Source: BHIP Records

As mentioned earlier, members prefer urban-based providers. Table 9.9 shows that urban providers managed to offer their services, such as outpatient consultations, at rates lower than rural providers, usually at about 3 percent less. Even if insurance pays for consultations, balance billing is still allowed, and members may shell out more for higher medicine or diagnostic charges in some facilities than in others. It appears that members recognized this and tended to patronize urban-based facilities, despite some travel costs.

Table 9.9 Distribution of Receipts, Urban vs. Rural, 1996

	% of Local Population Enrolled in BHIP*	No. of Patients Served in OPD	Utilization Rate	Receipts	% of Receipts	Avg. Cost Per OPD Consultation (in Pesos)
Urban	25%	36,919	59%	5,201,940	78%	141
Rural	8%	10,256	19%	1,482,230	22%	145
Total	12%	47,175	40%	6,684,170	100%	

Source: BHIP Records

For inpatient services, the average value paid per claim, or the costs of the service, is shown in Table 9.10. It can be observed from insurance records that the average cost of inpatient claims in the BHIP program (PhP1,248) was nearly double that of GHIP (PhP662). According to the providers' survey, the common causes for admissions were bronchopneumonia and acute gastroenteritis. The average cost figures for these admissions appeared to be normal for a two- to three-day stay in the hospital.

Table 9.10 Inpatient Services Costs

	Guimaras			Bukidnon		
	Benefits Paid	No. of Claims Paid	Pesos/Claim	Expenses	No. Served	Pesos/Beneficiary
1993	11,305	37	305.54			
1994	132,476	430	308.08	911,023	767	1,188
1995	444,199	118	3764.4	4,791,184	4,564	1,050
1996	468,014	870	537.95	8,932,173	6,757	1,322
1997	439,054	803	546.77	5,853,554	4,369	1,340
1998(July)				3,407,171	2,683	1,270
Total	1,495,048	2,258	662	23,895,105	19,140	1,248

Source: Provincial HIP Records

According to the household survey (as shown in Table 9.3), the average stay was four days for Bukidnon and seven to 10 days for Guimaras. It cannot be discounted that the rather lengthy stay for Guimaras may be attributed to the fact that only a hospital admission can allow use of benefits. Some doctors interviewed mentioned that they would ask patients to stay overnight just to take advantage of the medicine allowance that goes with hospitalization. Of course, the severity of illness in a poor area such as Guimaras is another likely reason for the patient's longer hospital stay.

9.3.2 Operating Efficiency: Payments vs. Collections

The usual practice in a financial analysis is to estimate operating efficiency in terms of whether expenses incurred are covered by income received. For a social program, however, this measure may not be adequate, as expenses may have a greater social impact and therefore reflect savings realized elsewhere. Also, a scheme that collects more than it spends in benefits to members may not be socially beneficial.

Benefit payment as a proportion of premium collection shows whether insurance funds can cover benefit claims from the premiums collected. Table 9.11 shows that, despite low premiums, GHIP spent 54 percent of collections on benefits to members. BHIP, while collecting eight times more premium, spent five times more than GHIP for utilization expenses. With only 35 percent of utilization expenses covered by premiums, BHIP clearly could not cover utilization from premiums alone. Subsidies from the provincial government, which have become part of the yearly budget, cover 65 percent excess of utilization over premium collections. Although budget support from the provincial government was intended only to cover premium shortfalls, it can now be viewed as a commitment to the program. BHIP offers a wider array of services, including dental and outpatient services. Clearly, these benefits could not have been afforded by contributions from members alone.

Utilization expenses have become an increasing proportion of premiums for both provincial programs. In 1997, efficiency was improved in both the GHIP and BHIP, however, BHIP figures for the first half of 1997 showed inefficiency levels more than double from 1996. The benefit structure for BHIP, combined with the economic structure of physician services in the province, may provide incentives for inefficiency.

Table 9.11 Utilization Expense as Proportion of Premiums

Year	Guimaras			Bukidnon			
	Utilization Pesos	Collections Pesos	Util'z Col'n	Utilization Pesos	Collections Pesos	Util'z Col'n	Budget Support
1993	11,305	146,908	8				
1994	132,476	643,264	21	2,490,955	1,446,771	172.2	3.0M
1995	444,199	647,821	69	10,589,036	3,770,556	280.8	7.1M
1996	468,014	602,302	78	16,779,234	4,948,981	339.0	11.6M
1997	139,054	732,400	60	10,575,537	4,957,088	213.3	12.1M
1998 (July)				7,073,680	1,597,970	442.7	12.0M
Total	1,195,048	2,772,695	53.9	47,508,442	16,721,366	284.1	45.8M

Source: Provincial HIP Records

9.4 Acceptability and Sustainability

That the two provincial schemes still continue to survive may be largely traced to their wide acceptability in the provinces. This fact needs to be qualified, however, because the schemes have not taken off in enrollment terms as projected. On the other hand, enrollment may not be entirely adequate as a gauge of satisfaction because it reflects the marketing efforts as much as consumer demand.

9.4.1 Acceptability to Providers

From the provider's perspective, program support can be gleaned from the investments provider participants have made since joining the program. Approximately 50 percent of respondents invested in supporting the program. One-fourth invested in constructing additional workspace and purchased new equipment. About 16 percent set up and stocked up on medicines through a pharmacy, while one provider reported giving additional clinic hours.

Despite their support, more than half of BHIP provider respondents expressed dissatisfaction with the fees they receive from the scheme. They believe that the benefits provided to the patients far exceed the premiums for members. Respondents also complained that an increase in fee payments may be needed as providers are receiving much less from the program than they are from their private patients. Guimaras providers shared the same sentiments. They further opined that the benefits from GHIP were too limited.

In Bukidnon, participation initially began by invitation to the different societies, but program managers have become more selective since some physicians and dentists were suspended due to noncompliance and other irregularities.

9.4.2 Acceptability to Members

Plan members expressed overall satisfaction with the program. Respondents believed that the provincial schemes reached the poor, with 100 percent and 97 percent agreement from Bukidnon and Guimaras, respectively. The program therefore can be seen to have achieved its objective of being an assistance program. As an insurance program, however, much leaves to be desired, as is further discussed in the following section on sustainability.

Respondents in the two provinces ranked accessibility of health services as the most attractive feature of the plan. For Guimaras respondents, this stood out as the most attractive feature, while in Bukidnon, the outpatient services/benefits and “immediate accommodation” were also cited as two attractive features.

When asked whether they were still willing to pay additional premiums, 62 percent of household respondents in Bukidnon and 78 percent in Guimaras expressed willingness to pay additional premiums. There was a tendency to round off their contributions to the next figure, such that Bukidnon respondents were willing to pay an additional PhP280 a year and Guimaras, an additional PhP40 to PhP50. This will make annual premium payments PhP1000 in Bukidnon and PhP110 in Guimaras.

The program appears to have widespread cultural acceptance. In Guimaras, for example, some respondents believed that their insurance identification card might actually be their protection from sickness. They related stories of how someone they knew got sick just when he/she did not renew his/her membership.

9.4.3 Sustainability

Whether the program can be self-sustaining from members’ contributions alone remains unlikely because of challenges in enrollment, financial sustainability, and administrative capacities.

Target enrollment has to be achieved for Bukidnon. As cited earlier, recruitment and enrollment hinge on marketing efforts as much as affordability. The financial crisis of the past year has led to faltering membership, yet some see the crisis as precisely the reason why they have to maintain their membership. Just as “one could not afford to get sick,” long-time members believe that “one could

Both GHIP and BHIP accept only household enrollment; however, this does not appear to be sufficient to address adverse selection issues manifested in high utilization rates. Widespread risk pooling can be achieved with a large enrollment base. Expanding the enrollment base could be made possible by targeting villages for possible recruitment. This would entail marketing to local officials to help enroll the whole village.

Currently, a larger enrollment translates into higher expenses, without adequate utilization safeguards. It also means that scale economies have not been achieved. It would require a much larger membership base and more efficient operations to realize such economies.

These programs may not realize financial sustainability in terms of absence of subsidies for some time. By design, GHIP incorporated counterpart funding from local government units to household contributions. BHIP did not include current subsidy levels of 65 percent in its design, but because of the expanded benefit package offered to members and the structure of the provider market, program

costs have been high and the subsidy has been necessary. Members want to see further improvements in the program in terms of increases in benefits, through higher ceilings on medicines and laboratory fees and by including dental filling and prophylaxis treatment in dental benefits. These benefits are not likely to be offered by the program given its current level of expenditures and operations.

Nonmembers interviewed did not take advantage of the program largely because they were not aware of it. It appears that the information campaigns and marketing efforts have been inadequate in reaching these people. There are other administrative challenges as well. Bukidnon members complained of the verification process they had to undergo before their passbooks could be released. For Guimaras members, it was the renewal of their identification cards that took time. Administrative issues are tackled in another paper, which points to certain skill limitations of program staff and managers.

The goal of sustainability needs to be further examined for decentralized schemes. If premiums paid by members are to be the sole source of operating income, then substantial inequalities will develop within the provinces and across areas over time. Provincial governments are likely to continue contributing towards the fund to promote equity. Likewise, central governments need to contribute for the same reasons.

9.5 Health Status

The program's impact on the health status of the population cannot be readily discerned in the absence of benchmark data. According to the results of the household survey, there were no differences in complaints about health between members and nonmembers. Providers were equally divided on the question of whether insurance members are less healthy than nonmembers. The common causes for health consultations were upper respiratory tract infection, acute gastroenteritis, and dental caries.

From the household's perspective, households were shown to have used their benefit allowances by seeking consultations for cough and colds, fever, and flu. This appears to be an expensive proposition (the average expense for visits in Bukidnon was P PhP335), considering that these complaints are self-limiting. The survey also showed tendencies towards irrational drug use, abetted by the coverage of medicines in the benefit package, as well as the vertical integration of outpatient services. Households put a high premium on their benefits for medicines. In both areas, an overwhelming majority (74 percent in Bukidnon and 75 percent Guimaras) replied "affirmative" to the statement: "A doctor who does not prescribe medicines for consultations is not a good doctor." Complications arising from irrational drug use can only be surmised.

10. Summary of Findings

Table 10.1 summarizes the critical aspects of the performance of the two provincial HIPs. The discussion below aims to examine effective mechanisms (what works) to achieve health financing reform goals.

Equity considerations imply that the programs were able to reach the low-income group as well as those unable to access basic health services because of physical and financial limitations. Improved cost-sharing mechanisms promote wider coverage. Local governments are in the best position to provide counterpart contributions to household premiums for health insurance coverage.

Even if the poor appear to be reached, the fact that premiums do not distinguish by income types shows less consciousness of solidarity or cross-subsidization. However, the complexity of the system may tax current management capacities.

Table 10.1 Summary of Findings

Variable	Indicator	BHIP	GHIP
Equity	Access	<ul style="list-style-type: none"> ▲ members were better educated; slight differences in age and income compared to nonmembers ▲ Members from more remote areas stayed in the program the longest 	<ul style="list-style-type: none"> ▲ members were older, with lower income and educational attainment
	Risk pooling	<ul style="list-style-type: none"> ▲ equally distributed among income classes 	<ul style="list-style-type: none"> ▲ larger enrollment base
	Distribution of costs	<ul style="list-style-type: none"> ▲ premiums did not vary by income 	<ul style="list-style-type: none"> ▲ premiums did not vary by income
Allocative Efficiency	Outpatient vs. Inpatient utilization	<ul style="list-style-type: none"> ▲ higher expenditures for OP for members ▲ higher inpatient rates than outpatient utilization 	<ul style="list-style-type: none"> ▲ high outpatient rates that are not covered, reflect greater health need; higher average costs of confinement; ▲ longer LOS
	Utilization rates	<ul style="list-style-type: none"> ▲ generally high utilization rate ▲ higher among member than non-members ▲ bottom income group had highest utilization rate for outpatient services 	<ul style="list-style-type: none"> ▲ generally high utilization rate ▲ inpatient admissions directly related to income and length of membership
	Public vs. private health care providers	<ul style="list-style-type: none"> ▲ members preferred private over public ▲ 99% of members went to private providers 	<ul style="list-style-type: none"> ▲ only public providers were available, except when referrals were made to Iloilo City
	Primary vs. tertiary	<ul style="list-style-type: none"> ▲ use of health center minimal, probably because only 18% of municipal health providers were accredited 	<ul style="list-style-type: none"> ▲ majority went to hospital for first-level contact
	Urban-rural	<ul style="list-style-type: none"> ▲ more rural providers 	<ul style="list-style-type: none"> ▲ not applicable

Variable	Indicator	BHIP	GHIP
		<ul style="list-style-type: none"> ▲ more urban-based members 	
Efficiency of Operations	Average costs	<ul style="list-style-type: none"> ▲ charges lower in private than public providers ▲ lower in urban than rural providers 	<ul style="list-style-type: none"> ▲ longer length of stay (7-10 days)
	Payments vs. collections	<ul style="list-style-type: none"> ▲ highly subsidized (collections paid for only 35% of utilization expenses) 	<ul style="list-style-type: none"> ▲ 54% of collections spent on payments
	Structure of physician services market	<ul style="list-style-type: none"> ▲ many providers also own hospitals, blunting cost-control efforts ▲ wide dispersion of private physicians results in geographic equity 	<ul style="list-style-type: none"> ▲ use of only public inpatient services allow greater utilization controls and lower average or unit costs
Institutional Sustainability	Financial sustainability	<ul style="list-style-type: none"> ▲ high subsidy levels prevent expansion 	<ul style="list-style-type: none"> ▲ some villages provide financial support ▲ subsidy levels designed to support entire population ▲ made capital investment on a hospital wing from member contributions
	Administrative capacities	<ul style="list-style-type: none"> ▲ skills gaps in financial management 	<ul style="list-style-type: none"> ▲ highly motivated, dispersed recruiters
	Acceptability to plan members and providers	<ul style="list-style-type: none"> ▲ many providers made investments in support of the program, but complained that BHIP reimbursements were relatively low ▲ members expressed overall satisfaction and were willing to increase payments 	<ul style="list-style-type: none"> ▲ complained that GHIP did not pay for physician services and that benefits were too limited ▲ members were satisfied and were willing to increase their premiums
Health Status	Differences in health-seeking behavior as proxy	<ul style="list-style-type: none"> ▲ relatively homogeneous health conditions between members and nonmembers 	<ul style="list-style-type: none"> ▲ longer stays; costlier illnesses

For allocative efficiency, health insurance improves access to private health services. Without a deliberate design to channel utilization towards appropriate levels, cost pressures will arise. BHIP, with its private providers, has failed to maximize the government's primary-level facilities, thereby creating the push for costly secondary- and tertiary-level facilities.

GHIP, by utilizing public frontline services as points of recruitment, has been able to maximize its primary levels. However, this has been insufficient because support value for confinement covers a miniscule proportion (12 percent) of expenses for hospital services.

Technical efficiency was not fully explored due to data limitations. Efficiency in terms of operating incentives was measured and indicated that urban and private facilities appeared to be more efficient and better able to provide services at lower average charges than rural and public facilities. On the whole, operating efficiency in the programs was limited. High subsidy levels due to high utilization appear to be indefensible in the face of the prevalence of low-cost illnesses and declining membership. Inefficiencies can be attributed to ineffective market structures in the physician services market.

11. Conclusion

Consultative discussions identified possible areas for further action and support. The new administration at PHIC, which manages the NHIP, is open to studying revisions to the IRR. Suggestions were also drawn from the fieldwork and consultative discussions. Specifically, needs in the following areas were identified:

1. Improving Service Provision through Insurance and Delivery Mix

The Bukidnon experience has shown that a capitation system for outpatient services can be possible and acceptable to providers. However, due to the demands of site-specific supervision and monitoring, this type of system may not be amenable on a vast national scale. More pilot studies need to be undertaken in other provinces, innovating especially in areas where the vertical integration of service provision is cut. That is, there should be clear primary care providers or gatekeepers with no direct financial stake in inpatient services.

In the interim, while the NHIP concentrates on improving its inpatient benefit system, experiments can be conducted, with active NHIP participation and financial support, on alternative contracting systems for different service delivery at local levels. The direct supervision can be lodged with provincial governments. This can be initiated more systematically with the next recommendation.

2. A Policy Study on “Increasing Market Competence through LGU-Driven Health Insurance”

Such a policy study can put together initiatives from other provinces, including those that adopted the indigent program of PHIC. It can assess provincial or subprovincial level markets in terms of buyers’ behavior, rivalry within and among formal insurance substitutes including HMOs, and nonformal systems. This can take on a more industrial organization type of analysis.

The following activities are forward-looking in terms of examining specific options for interface. There are initiatives that can be undertaken to explore possible options.

3. A Feasibility Study for a Health Reinsurance Corporation, a PHIC Subsidiary

One of the areas provincial governments suggested for PHIC was the institutionalization of a reinsurance mechanism to cover high loss ratios. Risk pooling is one effective method for reducing risk. The larger and more heterogeneous the risk pool is, the lower the risk. Since the number of enrollees in the provincial HIP schemes is relatively small and is exposed to the same hazards, risk reduction is limited. In the event of epidemics (recent dengue fever affected other provinces), catastrophic diseases, and other unexpected events, the pooled funds are at risk. A reinsurance mechanism can spread risk across provinces and over a larger risk pool by accepting a fraction of premiums from local health insurance schemes. In return, the reinsurance body will assume a share in the expenses of the insured. Reinsurance can constitute a major contribution of PHIC to local and provincial initiatives for equity considerations.

4. A Health Insurance Stabilization Fund

A variation of this reinsurance scheme is a form of a health insurance stabilization fund, which is essentially a buffer fund. It can work like the oil price stabilization fund where a fund is established to provide credit to provincial health insurance schemes in times of deficit and gets paid back in times of surplus. Though this scheme does not increase the risk pool, it addresses liquidity problems among health insurance schemes.

A reinsurance mechanism can be an advantage since it can take on a regulatory role among provincial HIPs. Provincial HIPs are exposed not only to health risks but to political, organizational, and currency risks as well. It will be in the best interest of the reinsurer, and the reinsured, to manage and reduce all these threats in order to minimize losses.

5. A Feasibility Study for the Social Health Insurance Ventures (SHIV), Inc.

This can be another subsidiary for PHIC. The SHIV primary function can be designated to install LGU-based HIPs on a built-operate-transfer (BOT) scheme. BOT schemes are widely adopted in various areas such as highways and utilities. This is one area where private-public partnerships can be enhanced. This can be an opportunity to show that social health insurance can be a viable venture for communities and private firms.

Managing an HIP is complicated and requires integrative knowledge in management and economics, specifically areas like risk management, health service administration, financial and operation controls, marketing, strategic management, and health economics. Consequently, there are large capacity and training needs in both national and local health insurance schemes. The health insurance schemes got started by simply assembling a group of local physicians, lawyers, accountants, and planning officers.

A more effective approach in replicating provincial HIPs is to establish an organization that will develop a capability in installing health insurance systems. This organization can install viable systems and operate them while the local personnel, technicians, managers, and leaders undergo a learning curve. Once local personnel have learned how to operate the system, management can be transferred.

6. Making Health Boards Work: A Study on Health and Governance

Provinces comprise the next viable operational level (after national) for schemes requiring a large risk pool. But provinces, per se, need to be organized more strongly at district levels. The district level is the weakest link in the health system, as shown by the gap between municipal and provincial service loyalties. Resource allocation decisions by local governments, like the decision to provide budgetary support to insurance programs, are made through the local health boards. The key to making decentralization work is through local health boards. Strengthening capacities below the national level requires investments in training, especially for strategic planning and evidence-based decision making. Activities can include a training needs assessment for health boards and health committees. Another output can be in the form of a guidebook for LGU-based health managers and policymakers. This can be coordinated at the national level, through the DOH, or directly undertaken by the provincial bodies, through the HIPs.

In conclusion, this study has shown how health financing schemes operate in two Philippine provinces. Despite weaknesses in allocative and technical areas, these schemes remain a viable option

in reaching poorer constituents. Large subsidies to these schemes can be viewed as demonstrations of local governments' commitments to make a difference in their constituents' health. The programs' viability requires a more deliberate attempt from policy to locate the programs in the national scheme of things. The potential of using the health insurance fund to influence changes in behavior remains to be realized. It is hoped that the analyses and concerns raised in this study can contribute to a better understanding of the competence of agents and the markets that flow from their interaction to assist policy towards the achievement of universal health insurance coverage in the country.

The Philippine population is a highly heterogeneous market in terms of its health financing needs. Different market segments can be defined according to the following variables: income class, industry, proximity to service providers, health status, health-related environmental factors, and type of municipality. The two provincial HIPs studied here prove that LGUs are potential suppliers of site-specific health insurance. There has been, on the average, approximately five years of experience in delivering a popular health insurance system.

Annex A. Demographic Overview

Table A.1 Basic Indicators, Philippines

	GDP/Capita Annual Growth Rate ¹	Annual Growth Rates, Population ²	Life Expectancy (Years)	Infant Mortality Rates (per 1,000 live births)
1965-1980	2.9	2.9	1960: 53	71
1980-1995	-0.4	2.5	1994: 67	42
1990-1995	.01	1.9		

Table A.2 Regional Profiles

Region/Province	Population (1995)	Percent of Population	Average Income 1997 p./	Annual Per Capita Poverty Threshold <u>a/</u> (PHP)	Incidence of Poor Families
Philippines	68,616,536	100%	123,881	11,388	32.1
National Capital Region	9,454,040	14%	274,823	14,360	7.1
Cordillera Administrative Region	1,254,838	2%	112,595	12,744	42.3
Ilocos Region	3,803,890	6%	102,741	11,981	37.6
Cagayan Valley	2,536,035	4%	86,818	9,873	31.6
Central Luzon	6,932,570	10%	133,831	12,073	16.8
Southern Tagalog	9,943,096	14%	132,212	12,506	25.7
Bicol Region	4,325,307	6%	77,098	10,497	50.1
Western Visayas +	5,776,938	8%	86,733	10,800	41.6
Central Visayas	5,014,588	7%	85,500	8,726	34.2
Eastern Visayas	3,366,917	5%	68,018	8,755	40.7
Western Mindanao	2,794,659	4%	89,370	9,670	39.8
Northern Mindanao ++	2,483,272	4%	99,473	10,455	46.8
Central Mindanao	4,604,158	7%	93,064	10,489	37.9
Autonomous Region for Muslim Mindanao*	2,359,808	3%	81,183	11,155	49.1
Caraga**	2,020,903	3%	74,729	11,214	58.6
	1,942,687	3%	71,806		

1/ Created into a region under RA No. 7864 dated November 26, 1989, taken from Region 9 and Region 12

2/ Created into a region under RA No. 7901 dated February 23, 1995, taken from Region 10 and Region 11

a/ The annual per capita income required or the amount to be spent to satisfy nutritional requirements (2,000 calories) and other basic needs.

b/ The proportion of poor families to total number of families.

p/ preliminary as based on the preliminary results of the 1997 Family Income and Expenditures Survey (FIES)

Sources: **National Statistics Office**

National Mapping and Resource Information Authority, DENR

Technical Working Group on Income Statistics, NSCB

+ Guimaras in this region ++ Bukidnon in this region

¹ Lim (1998)

² World Development Reports, Various Issues

Table A.3 Nutrition Status, 1995

% of preschool children moderately and severely underweight	7.5
% of school children moderately and severely underweight	6.2
Prevalence of iron deficiency anemia among infants	46.4
Prevalence of Bitot spots as manifestation of Vitamin A deficiency in preschoolers	0.08
Prevalence of goiter as manifestation of Iodine Deficiency Disorder	4.9

Table A.4 Leading Causes

Morbidity	Mortality
1. Diarrhea	1. Diseases of the Heart
2. Pneumonia	2. Diseases of the Vascular System
3. Bronchitis	3. Pneumonias
4. Influenza	4. Malignant Neoplasm
5. T.B. Respiratory	5. Tuberculosis, All Forms
6. Malaria	6. Accidents
7. Diseases of the Heart	7. Chronic Obstructive Pulmonary Disease and Allied Conditions
8. Measles	8. Diarrheal Diseases
9. Chicken Pox	9. Other Diseases of the Respiratory System
10. Dengue Fever	10. Diabetes Mellitus

Figure A.1 Location Map

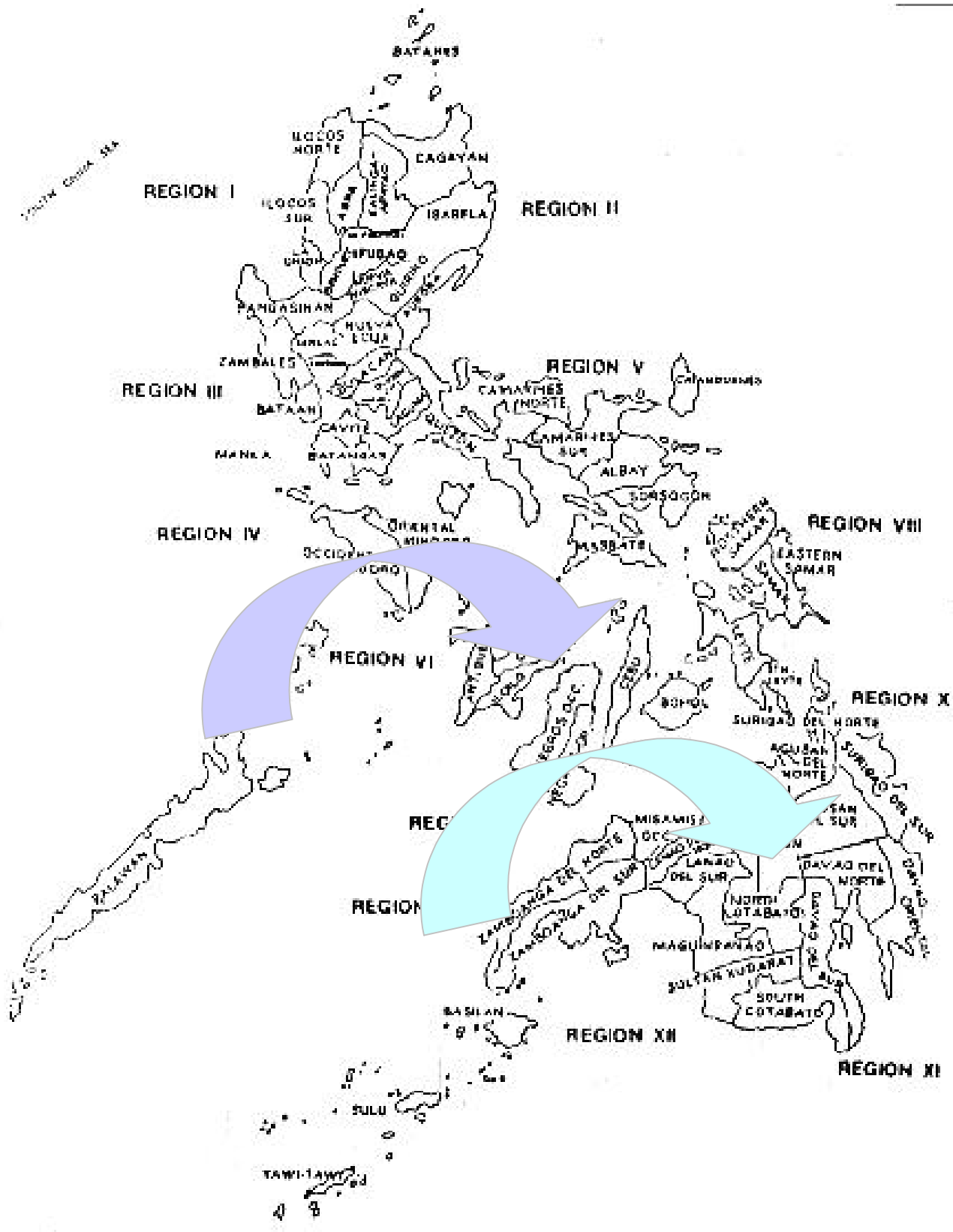


Table A.5 Comparison of 10 Leading Causes of Morbidity, by Rank

Cause	Philippines	Guimaras	Bukidnon
1. Diarrhea	1	2	4
2. Pneumonia	2	1	3
3. Bronchitis	3	3	1
4. Influenza	4	8	2
5. T.B. Respiratory	5	4	7
6. Malaria	6		
7. Diseases of the Heart	7	5	5
8. Measles	8		9
9. Chicken Pox	9	7	6
10. Dengue Fever	10		
11. Schistosomiasis			8
12. Typhoid Fever		6	10
13. Hepatitis Viral		9	
14. Scabies		10	

Source: Modified Field Health Service Information System (MFHSIS)
Health Intelligence Service
Bukidnon Provincial Health Officer Annual Report, 1997
Guimaras Provincial Health Officer Annual Report, 1997

Table A.6 Comparison of 10 Leading Causes of Mortality, by Rank

Leading Causes of Mortality	National	Guimaras	Bukidnon
1. Diseases of the Heart	1	2	1
2. Diseases of the Vascular System	2	3	
3. Pneumonia	3	1	3
4. Malignant Neoplasm	4	4	5
5. Tuberculosis, All Forms	5	5	4
6. Accidents	6	7	2
Chronic Obstructive Pulmonary Disease and Allied Conditions	7		
8. Diarrheal Diseases	8	10	8
9. Other Diseases of the Respiratory Sys.	8		
10. Diabetes Mellitus	10	9	
11. Congestive Heart Failure		6	
12. Renal Failure		8	6
13. Peptic Ulcers			

Source: Modified Field Health Service Information System (MFHSIS)
Health Intelligence Service
Bukidnon Provincial Health Officer Annual Report, 1997
Guimaras Provincial Health Officer Annual Report, 1997

Table A.7 Basis of DILG Income Classification

Provincial

First Class	The provinces and cities that have obtained an average annual income of 30 million pesos or more
Second Class	The provinces and cities that have obtained an average annual income of 20 million pesos or more but less than 30 million pesos
Third Class	The provinces and cities that have obtained an average annual income of 15 million pesos or more but less than 20 million pesos
Fourth Class	The provinces and cities that have obtained an average annual income of 10 million pesos or more but less than 15 million pesos
Fifth Class	The provinces and cities that have obtained an average annual income of 5 million pesos or more but less than 10 million pesos
Sixth Class	The provinces and cities that have obtained an average annual income of less than 5 million pesos

Municipal

First Class	Municipalities that have obtained an average annual income of 15 million pesos or more
Second Class	Municipalities that have obtained an average annual income of 10 million pesos or more but less than 15 million pesos
Third Class	Municipalities that have obtained an average annual income of 5 million pesos or more but less than 10 million pesos
Fourth Class	Municipalities that have obtained an average annual income of 3 million pesos or more but less than 5 million pesos
Fifth Class	Municipalities that have obtained an average annual income of 1 million pesos or more but less than 3 million pesos
Sixth Class	Municipalities that have obtained an average annual income of less than 1 million pesos

Source: DILG, Quezon City

Table A.8 NHIP Fund Status and LGU Implementation**Fund Status as of September 30, 1997 (unaudited)**

	Pesos	
Private Sector (SSS)		14,632,988,240
Government Sector (GSIS)		105,336,461
Indigent Fund		
National Government Subsidy	50,000,000	
LGU Remittances	2,340,313	
Subtotal		52,340,313
PMCC Fund		838,507
Interest Income		367,211,969
Grand Total		15,158,718,490

Status of Servicing as of September 30, 1998

LGU	# of Qualified Households	# of Claims Filed	Avg. Value Paid Per Claim (in pesos)
Abra	2,198	314	1,261.14
Camiguin	706	27	1,424.12
Laguna	405	2	1,410.00

LGUs with PhilHealth—in Various Stages of Means Testing; as of August 31, 1998

LGU	Date MOA Signed	# of Households
1. Lanao del Norte	May 06, 1997	18,462
2. Antique	May 29, 1997	6,693
3. Surigao del Norte	June 18, 1997	16,128
4. Masbate	June 23, 1997	5,663
5. Eastern Samar	July 16, 1997	14,935
6. Ilocos Sur	July 07, 1997	8,177
7. Surigao del Sur	December 02, 1997	10,538
8. Ifugao Province	December 15, 1997	5,370
9. Passi, Iloilo	January 15, 1998	101
10. Iloilo Province	January 15, 1998	16,342
11. Capiz	January 30, 1998	5,533
12. Batanes	February 13, 1998	300
13. Batangas City	February 16, 1998	5,050
14. Butuan City	February 23, 1998	1,683
15. Apayao	February 25, 1998	700
16. Camarines Norte	March 03, 1998	2,668
17. Oriental Mindoro	March 23, 1998	5,503

Annex B. Bibliography

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