

**Prepaid Managed Health Care:  
The Emergence of HMOs as Alternative  
Financing Schemes in the Philippines**

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**I. The Research Problem**

**A. Introduction**

The increasing cost of health services in developed and developing countries has stimulated greater interest in the utilization and financing of these services. The question of how more resources can be generated, used more efficiently and distributed more equitably to ensure "Health for All by the Year 2000" was the central issue addressed by 1987 World Health Assembly. In this gathering, discussions were focused on the need to describe and reexamine, among others, resource generation and mobilization schemes for national health systems worldwide. The assembly sought to establish the foundation of, as well as trigger, a sustained and systematic search for, alternatives to current modes of planning, generating, distributing and utilizing scarce resources for health care.

In search for new and better ways, health administrators in developing countries have realized that they must start by analyzing how health care is financed in both the public and private sectors. To date, little is known how public and private components of the existing health system affect each other. Thus, very little account is known how these sectors affect or influence each other in the delivery and financing of health services.

As with most developing countries, the Philippines is still in the process of evolving a rational and responsive national health financing policy which suits the country's health needs given the existing patterns of producing, utilizing and distributing health resources. To address inequities and inefficiencies currently plaguing the system, a health financing scheme which determines who pays for what health care services and under what conditions could ensure equity as well as reward efficiency.

**B. The Research Problem**

The determination of a scheme through which the country hopes to optimize use of scarce resources, as well as effect redistribution to minimize inequities, will certainly be a complex process. This process will require studies of how the incentives and disincentives operating through the existing system of health care financing affect the behavior of providers, financiers and consumers of health services in the public, private and non-governmental sectors. Moreover, as key actors in health financing transactions, providers, financiers and consumers are likely to participate actively in the political processes through which changes in the structure of rewards and disincentives may be effected.

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\*Part of a larger study conducted jointly by the Philippine Institute for Development Studies (PIDS) and the Department of Health (DOH) under the Health Policy and Development Program. The program is financially supported by the International Health Policy Program (IHPP), an initiative of the Pew Charitable Trusts and the Carnegie Corporation of New York in cooperation with the World Bank (WB) and the World Health Organization. (WHO).

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In the absence of a national health care financing plan, certain forms of health financing schemes have emerged to help consumers deal with the rapidly rising costs of health care. Prepaid, managed health plans are now available to residents of the Metro Manila area and contiguous provinces, as well as in selected urban centers of the country. Through these plans, members may avail of a defined package of health services with no out of pocket cost upon availment, since these services have been prepaid.

This research seeks to look more closely into the emergence of these prepaid managed health plans. Since these organizations started operating in the country between the late seventies and early eighties, there has been very little empirical research done on the subject. To our knowledge, this research is the first attempt to look into the operations of HMOs or HMO-like organizations operating in the greater Metro Manila area and nearby provinces.

As a descriptive-analytical account of a fairly recent phenomenon in health care financing in the Philippines, this study will attempt to:

- 1) Identify and characterize the various HMOs operating within the greater Metro Manila area;
- 2) Describe the environment and the nature of these organizations, as well as the processes through which they finance and deliver health care services to their members.
- 3) Determine the relative advantage of HMOs vis-a-vis other forms of health financing on the basis of individual and corporate clients' perception of this advantage, and
- 4) Establish areas of policy intervention through which the Philippine government can more clearly signal to HMOs what is their appropriate role in the country's quest for a national health care financing policy.

### C. *Significance of the Study*

This research is viewed as an opportunity to take a closer and more critical look at a mode of health care financing developed in the United States which is slowly taking root in Philippine soil. International market forces and the similarity of Philippine and American health care delivery systems may have facilitated the adoption of HMOs in the Philippines. This is likely to occur through the stream of US trained medical professionals who observe developments in the American health scene regularly. However, the appropriateness of this type of health financing scheme to Philippine realities at this time has not yet been examined. The adoption of schemes from another cultural and economic setting should always be an occasion for raising crucial queries. Among the questions that can be raised in this case, are the following:

- 1) How similar in significant respects, are the conditions in the Philippines at the time HMOs evolved in Manila compared to those prevailing in the U.S. when the U.S. Congress passed the HMO Law of 1973?
- 2) As a crucial precondition to encourage the establishment of non-profit HMOs in the American society, their government extended substantive financial support for emerging HMOs. Should Philippine government extend that kind of financial support for the development of and to utilize the HMOs to increase competitiveness of the health care delivery system?
- 3) A description and analysis of the conditions under which HMOs emerge and operate in the Philippines will not only produce insights on the nature and performance of these organizations. It will likewise enable one to identify the conditions and factors which may allow HMOs to contribute to the

achievement of the desired goals of a Philippine health care financing policy. Thus, one can ask at least two questions:

3.1 Given the inequity in the distribution of health facilities and professionals, which tend to converge in strongly favored urban centers in the Philippines, will the development of HMOs be a force which can trigger a redistribution of these resources to less undeveloped areas?

3.2 Regardless of their effects on existing levels of inequities, can HMOs foster greater efficiency in the Philippine health care system?

In the spirit of critically examining the applicability and desirability of this financing scheme concepts and in the light of national realities, this study seeks to identify with the nationalist character of researches in the Philippine Studies Program. The protection and promotion of Filipino interests demand that a closer scrutiny of "imported" mechanisms be undertaken to ascertain their congruence with, and possible advancement of, the society's needs and aspirations, instead of being disruptive of its priorities.

#### *D. Methodology and Data Base*

This research was undertaken within a period of one year, starting from the second quarter of 1988 up to the end of 1989. Primary data for this study were collected through:

- 1) the examination of corporate papers filed by each of the HMOs registered with the Securities and Exchange Commission. Where no new corporation was organized, marketing and other corporate brochures providing information on premiums, programs and benefits were gathered and analyzed; and
- 2) the conduct of some 50 semi-structured interviews with HMO management officials, physicians accredited by HMOs, hospital administrators, sales agents, corporate and individual clients and government officials.

Secondary data were gathered through visits to major Metro Manila libraries as well as to government offices, notably, the Securities and Exchange Commission (SEC), the Office of the Insurance Commission (OIC), and the Philippine Medical Care Commission (PMCC).

The conduct of this study was supported by a grant from the Philippine Institute for Development Studies and the International Health Policy Program. A team of two research associates and three research assistants were involved in various stages of the research.

#### *E. Limitations of the Study*

As far as we know, this study is the first attempt to identify HMOs, describe and analyze their operations, and determine how the various participants in the structure (investors, managers, physicians, agents, and clients) view HMOs as an emerging mode of financing and delivering health care in the Metro Manila area and adjoining provinces. Prior to this, there was no ready information on just how many HMOs there were, who they were and how they financed and provided their services, much less on how satisfied their clients have been with their services. Constituting an undefined and therefore little known component of the medical services group, HMOs are not yet considered as a distinct category under the existing

Philippine Standard Industry Classification. Thus, in the SEC listing of firms, some of them fall within a catch-all category, which does not sufficiently capture the essence of their operations: "Insurance Activities not Elsewhere Classified". Others are considered part of the Medical Services Group. It became evident early in the research that making an initial list of these HMOs would be a significant starting point not only for this study but for other prospective researches on the topic, as well.

Relatively little known, unregulated and left almost entirely on its own, the young HMO industry in the Metro Manila area is evolving and seeking its own identity in the scheme of things in the country, with market competition providing the impetus to do well. There is no one source of ready and accurate information on the nature of their business and how they attract, maintain and serve their clients in the Metro Manila area. Aware of this fact, HMOs are wary of information seekers, competition, and for some, the prospect of government regulation.

In this context, any external query on their operations, their utilization levels and finances would understandably be suspect. For this reason, a number of HMO management officials were not keen on being interviewed by this researcher on their businesses. Despite a formal letter which explains the nature and institutional support for the study, some of the interviewees hinted that they could not really be sure that the researchers were not really prospective competitors contemplating on setting up their own HMO. This resulted in some interviewees giving guarded answers which tended to be rather broad and general in nature. Others would test the researcher's knowledge on the topic just to check her claims about the nature of the research. There was willingness to share information only if they could see that some of this is already known to the interviewer. The more judicious HMO manager interviewee would fish for information on the industry too, as they registered a tendency to react against the idea of government establishing policies to regulate HMOs. On the whole, providers of the HMO delivery systems, i.e., hospital administrators, doctors, and even sales agents and clients, were more cooperative than plan managers in providing information.

The results of this research must be appreciated within these limitations. While the researcher sought more detailed information on the basic structures and arrangements between HMOs and their network of providers, they were not immediately available from the HMO officials themselves. This prompted the researcher to resort to other sources such as the providers themselves. Readers are alerted to this limitation of the study. This data gathering experience is indicative of the difficulties which researchers are likely to encounter when seeking information from the private sector where there is no formally designated and accepted authority officially tasked with such a function. Under a highly competitive free market situation, information is a valuable resource which has its corresponding cost and is not just given to anyone who seeks it. Thus, the conduct and outcome of this study have been limited by this condition.

Being a pioneering research effort, this study did not benefit from the insights of earlier studies on the subject.

It is thus important to note that this research does not constitute an evaluation of HMOs *per se* nor of any one HMO as such. Moreover, unlike other studies which are able to start with a theoretical typology which they can test empirically, this study still seeks to evolve a typology of Philippine HMOs whose operations are based within Metro Manila area.

## **F. *Plan of the Volume***

The second chapter presents the theoretical issues raised in the literature on health financing. It focuses on the debate on who should assume main responsibility for the raising of resources for health and the question on risk-sharing as a mode of getting users of health services to contribute their share of the increasing costs of health care.

What is the unifying theme of Chapter III? It defines and delineates HMOs from other forms of health care financing schemes, identifies the various types of HMOs, and look into the beginnings of HMOs in the American setting. It also goes into the experience of some developing countries which have adopted HMOs as a form of financing the delivery of health care services.

Chapter IV describes and analyzes the national health situation, the characteristics of the Philippine health financing system, the magnitude and mode of health care financing and the general feature of HMOs in the Philippines.

Chapter V focuses on the emergence and the operations of profit-oriented HMOs with particular emphasis on HMOs marketing their plans in the Metro Manila area and other urban centers of the country.

Chapter VI discusses the essential features of non-market oriented HMOs and two alternative financing schemes which involve state participation at the national and local levels.

The last chapter summarizes the findings of the study and points to areas of policy intervention that these findings may suggest. It ends with a proposed research agenda which may lead to an evaluation of Philippine HMOs on more solid empirical ground.

## **II. Health Care Financing: Seeking Alternatives for Increasing Resources Without Exacerbating Inequities**

This chapter presents the theoretical issues on health care financing within the context of current trends of ensuring greater access to health care services as a way of promoting health. Of particular interest to the study are the questions on:

- a) the relationship between medicine and health;
- b) what health services people tend to pay for;
- c) market vs. public provision of health services, and
- d) the role of risk-sharing in health care financing

Distinction shall be made among health, health services and their different components, and health financing.

Health is not merely the absence of disease or any form of infirmity or disability. Beyond this, the World Health Organization (WHO) defines it as a state of complete physical, mental and social well being. It has been acknowledged that a country's level of social and economic development determines, to a



certain degree, the health status of its people. It is also recognized that the improvement of a society's overall health status is contingent not only on developments in the health sector alone but on the provision of other economic and social services such as adequate nutrition, safe drinking water, sanitation, education and housing (Abel Smith, 1978: 19) and perhaps, regular employment which provides access to all these basic services.

While the level of a country's development may be positively correlated with health standards, this is not simply because spending more on health services buy better health. Abel Smith noted that "the predominant reasons for the higher health standards of more developed countries are the higher level of nutrition, the more favorable environment and the adoption of certain patterns of behavior which are of special importance for the maintenance of health" (Abel Smith, 1978: 24). Moreover, the European experience in the forties indicate that the provision of more expensive service by doctors and hospitals per se does not explain differences in health standards either. The health standards of Europe in the eighteenth or nineteenth century improved long before the advent of scientific medicine. This was partly attributed to greater food production, better means of distributing food through better transport facilities, and later from the wider availability of clean water and the construction of efficient systems of sewage disposal.

Having established the inherent link between the level of economic development and the health status of a population, one may ask whether people get healthier as they get richer and are assured of easy access to medical professional. It may be commonplace to view advances in scientific medicines as also advancing health. However, this view is directly contradicted by theorists who argue that in fact, medical advances and physicians have increased illness. These two views are discussed below.

#### A. *Medicine and Health: Ideological Critiques*

There are two schools of thought on the relationship between health and medicine. The traditional view regards illnesses as largely a biological fact. It sees scientific medicine as the only way through which professionals can intervene to help disease-stricken patients deal with their illnesses. The other school of thought questions the soundness of this argument and attributes certain forms of illnesses to physicians' practices and to people's dependence on medical cure.

The advances of scientific medicine may have caused the current crisis in health care. Lesley Doyal points to three questionable assumptions about the relationship between medicine and health that is held in the traditional view. These assumptions are:

- 1) That the patterns of morbidity and mortality have little to do with social and economic environment in which they occur since the determinants of health and illnesses are biological.
- 2) That medicine is assumed to be a science and because it is scientific it is seen to produce an unchallengeable and autonomous body of knowledge which is isolated from the wider social and economic environment.
- 3) That scientific medicine is viewed as the only way through which people can deal with disease. Thus, medicine is considered good, *per se*, except that the supply is inadequate and there is a need to optimize its use (Lesley Doyal, 1981: 12).

These assumptions, likewise influence the academic approaches to the study of medicine. Thus, from the point of view of the sociology of medicine, Talcott Parsons views sick people as unable to comply

with their obligations in society, and to carry out their normal duties and therefore, need to be controlled. Aside from accepting the scientific and curative activities of medicine, Parsons has given medicine an added function of socialization and social control of the sick (Doyal, 1981: 16). Within its functionalist framework, traditional sociology of medicine does not see medical knowledge as a problem. In contrast to this uncritical acceptance of medicine, Ivan Illich analyzes the nature and content of medical practice to illustrate the damage, rather than the help, extended by the medical profession to those who are suffering from illness (Ivan Illich, 1976). He identifies three forms of illnesses which he calls *iatrogenesis* (from *iatros*, the Greek word for physician, and *genesis* meaning origin). Clinical iatrogenesis refers to the physical damage caused by doctors in their attempts to cure the sick. Social iatrogenesis, on the other hand arises from people's addiction to medical care as a solution to all their problems. Structural iatrogenesis results when patients lose their autonomy to heal themselves and their responsibility for individual health care is expropriated by the very system established to increase their capability to heal themselves (Illich cited in Doyal, 1981: 17).

Since Illich attributes all these to the industrialization of society, he proposes cultural rather than socio-economic changes in bringing about the deindustrialization. Doyal, however, criticizes this stance as it is proposed within a near social and economic vacuum. Using a Marxist framework, Doyal argues that:

...The problems at present plaguing the medical care systems of most developed countries do not merely reflect an immediate 'fiscal crisis', they can not adequately be explained simply in terms of the worldwide economic recession of the 1970s. Rather they reflect, first the obvious and growing contradiction between health and the pursuit of profit under capitalism, and second the contradictions inherent in the particular forms of medical practice which have evolved within capitalist societies.

..These considerations not only apply to the metropolitan countries, but must also serve as the starting point in any attempt to explain the enormous burden of disease and premature death still borne by the mass of the population in underdeveloped parts of the world (Doyal, 1981: 291).

The call for the adoption of the primary health care approach appears to be one of the responses to the concern raised by the latter school of thought.

The need to free men from the debilitating dependency on medical professionals and to restore their sense of confidence in their and their community's capacity to deal with their health needs are central to the concept of primary health care advocated through the Alma Ata Declaration in 1978. It explicitly seeks to empower even the poorest and remotest communities to deal with their health needs at every stage of their development in the spirit of self-reliance and self-determination.

Even as new theories about the process of promoting health through self-help are evolved, the dilemma of increasing resources devoted to health care continues to beset developing countries where resources are never sufficient to meet the health needs of rapidly growing populations. This dilemma is not confined merely to having enough for health, it is complicated by the fact that there are varying levels of health care and individuals are not always willing to pay for some of these services; especially public health interventions which are intended to prevent the outbreak of major communicable diseases.

Who tends to pay for what types of health services? What is usually covered when one speaks of health services? These are discussed in the following portion of this study.

### **B. *Health Care Financing: Major Forms and Types of Health Services Supported***

Health care refers to those services provided to individuals or communities by agents of health services or professionals for the purpose of promoting, maintaining, monitoring, or restoring health. Health care is broader than, and not limited to medical care, which implies therapeutic action by or under the supervision of a physician. Health services are those performed by health care professionals or by others under their direction, for the purpose of promoting, maintaining or restoring health. In addition to personal health care, health services include measure for health protection and health education (Last, 1983:44).

Health care financing refers to the identification, mobilization and utilization of resources (cash or in kind) to support or pay, partially or fully, the production or the delivery of health services.

What are the traditional sources of funds or resources for health services? Sources may be classified on the basis of a) service fee at the time of use (indirectly financed) and services for full payment (directly financed) (Abel-Smith, 1963: 18-19; Abel-Smith, 1978: 73); b) public and private sources (Zschock, 1979: 19, 33); and c) agency or body that originally provides the funds (Mach and Abel-Smith, 1983: 18-19).

Under the first type, Abel-Smith made a distinction between funds made available to health services through indirect payment (general government funds, compulsory insurance funds, voluntary insurance funds; employment insurance, charitable donations and foreign aid); and funds which persons pay directly to the provider in return for goods and services received (payment by recipient in return for services excluding insurance payment to compulsory and voluntary insurance funds).

Zschock's proposed categorization puts premium on public and private sources of funds. General tax revenues, deficit financing (domestic or international borrowing) sales tax revenues, social insurance and income from lotteries and betting fall under the first category. Private funding sources would include direct employer financing, public health insurance, charitable contributions, direct household expenditure and consumer self-help (Zschock, 1979: 20, 27).

Mach and Abel Smith's categorization scheme has three main types: private, public and external cooperation sources. The four sources falling under the public category are: Ministry of Health, other government departments, regions and local government and compulsory health insurance. Private sources, on the other hand, cover private health insurance, private employees, local donation (cash), and private household's donated labor. External cooperation includes official or non-official assistance from outside the country (Mach and Abel Smith, 1983: 18-19).

The three modes of categorization are important in that each scheme provides a different way of sorting information about:

- a) what groups of the population are paying the cost of health services;
- b) how the payment they make compares with the value of the services they receive;
- c) how the mode of financing affects what is provided and to whom it is provided;

d) who ultimately controls the spending (the government, social security funds, insurance companies, profit or non profit hospital or other bodies) and how that control is exercised; and e) how financing can influence the orientation of the service (prevention vs. cure), the setting where care is provided (in-patient, ambulatory or domicillary), the level of technology used, quality of care provided, geographic distribution of health resources and the cost of providing the services (Abel Smith, 1963: 74).

Health services do not constitute one homogeneous set of economic goods. For financing purposes, it is significant to distinguish between preventive and curative services. Looking at the type of health services provided in a number of countries, and the percentage of total expenditure in health devoted for these services, De Feranti came up with the following table:

**Table 1 : Type of Health Services and Percentage of Total Expenditures Devoted For Each**

Services	% of Total Expenditure in Health
<b>A. <u>Curative Care</u></b>	70 to 87
1. Personal services (care of patients) by health facilities and independent providers, including traditional practitioners	
2. Purchases of medicines	
<b>B. <u>Preventive Services: patient related</u></b>	10 to 20
1. Maternal and child health clinics, at health facilities	
2. Community health programs (e.g., home visiting)	
<b>C. <u>Preventive Services: Other</u></b>	3 to 10
1. Disease Control programs	
2. Sanitation	
3. Education & Promotion of health and hygiene	
4. Control of pests and zoonotic disease	
5. Monitoring disease patterns	
<b>Total:</b>	100

*Source: De Feranti, 1985: 27*

It will be noted that some of these modes of organizing information along major health care financing questions as listed above, are directly relevant to this study. Thus, on the issue of market versus public provision of services, the concern inevitably touches on who receives what type of services as well as what people are willing to pay for and why. Moreover, risk-sharing, as an element of a financing scheme, becomes a point of interest once social insurance and other forms of risk-pooling are resorted to as a way of financing health services.

It is evident from the array of questions listed above that equity and efficiency norms are inextricably interwoven in each of these set of issues. There is efficiency if the costs of producing the services are reduced for individual health services and the administrative cost for collecting and transferring funds are not greater than the amount involved. Equity, on the other hand, asks who bears the burden of the cost of services and whether there is equality of access to health care for all.

The twin goals of efficiency and equity which most health financing schemes seek to achieve are not easily reconciled as they appear. What brings about an efficient system may promote inequities as in the decision to cover only the employed sector to facilitate collection and minimize costs and for these reasons, to exclude the unemployed from a social insurance scheme because of the difficulty of setting up an efficient and effective mechanism for collecting premiums from low income group or communities. The efficiency-equity conflict is a recurring dilemma that confronts policy makers of developing countries where there are marked income inequities. While some countries may be more successful in balancing these conflicting goals, others have to make a trade-off in that they have to decide to pursue one at the expense of the other.

In developing countries where more marked inequities between the urban economic elite and the rural poor exist, there is a greater need to adopt health financing schemes which distribute the burden for bearing the costs of health services across the rich and the poor and the healthy and the sick. Risk-sharing mechanisms where the state has a principal role are usually viewed as a form of social insurance. This constitutes a particular class of insurance which generally covers those designated to protect wage earners and their dependents, as workmen's compensation, old age, underemployment and accident and health insurance. Social insurance is generally regarded as applicable only to a defined population.

The Canadian and American health financing system which rely on state and market mechanism respectively, for the provision of resources for health as well as in checking rapidly increasing health costs, may be compared in terms of their ability to assist the poorer and weaker sectors of the society in negotiating for better terms. The Canadian system uses public system to purchase public insurance for comprehensive individual care. The Americans, on the other hand, making use of the competition principle, resorts to private collective purchasing agencies to bargain with provider on behalf of individuals.

In an incisive piece, Robert G. Evans has described how the use of public health insurance has enabled the Canadian government to implement a public health insurance system which succeeded in redistributing financial risks associated with illness and health care. It has also influenced directly both the mix and the quality of the different services provided, especially prices (Evans, 1987: 116).

Stressing the inadequacies of economic analysis to fully understand the process through which public health insurance enables buyers, through their political representatives, to bargain with providers over both price and quantity of care and thus to control over all system costs in a way that individual patients can not, Evans points out that "standard theoretical analyses of the effects of insurance coverage on health care costs, taking no account of the difference between public and private system, relatively 'predict' that more extensive coverage must lead to higher cost (Evans, 1987: 116).

Using empirical data on Canadian and American health care costs from the fifties up to the early eighties, Evans succeeded in proving that Canada has controlled health care spending throughout the seventies and the eighties. Despite the close similarities of the two systems, the crucial distinction came

in the American decision to utilize private insurances whereas Canada decided on public systems. In Evans' words:

**"The critical divergence in policy came in reaction to the obvious inability of private insurers to cover the high risk and/or poor, where the health care needs, on an individual basis, were greatest. In Canada, the decision was made to set up universal public systems in each province which would, through cross-subsidization, be able to include these groups. In the United States, on the other hand, categorical programs were introduced to assist the elderly, the poor and those with special health or social conditions; but the private system was left to reimburse the care for the majority of the population (Evans, 1987: 121).**

The Canadian/US contrast is a rare opportunity to show how private, for profit motives will accelerate the process of cost escalation since costs are to the people, as sales revenues are to firms (Evans, 1987: 129).

The Canadian experience shows that universal comprehensive coverage, cost control and great political popularity are simultaneously possible. This has been achieved through public monopoly, not of delivery, but of payment. This experience likewise indicates the need to reorganize the institutional structure to get the incentives right. But as Evans put it, "The key incentives and the crucial behavior are those not of individuals, but of groups; and the necessary analysis is political as much as, or more than, economic" (Evans, 1987: 132).

The perceptible shift of the U.S. health care economy from guild to market over time is empirically confirmed by Enthoven (1987). He noted the remarkable speed with which the more competitive guild system of the past fifty years has been shifting to a competitive market system. Competitive Medical Plans (CMP, of which HMOs are prototypes) figure prominently in this shift. Central to this process is the competition that must take place annually as buyers decide over various choices of comprehensive health care financing and delivery plans.

This concept of market competition is founded on four ideas. First, a Competitive Medical Plan (CMP) (a generic term that includes HMOs, Preferred Provider Insurance, etc.) links insurance and a limited set of providers such that insurance premiums reflect the capacity of provider to control cost. Secondly, every consumer must have an annual choice to select from among the different plans serving his area. Thirdly, this choice must be cost-conscious. This market free choice emphasizes cost consciousness at the time of annual choice of health care plan. Finally, market competition does not mean "free market". There must be rules to make the competition equitable and effective. Rules must assure that the health plans are viable because they give better service at less cost and not merely because they select healthier people to insure (Enthoven, 1987: 246).

Given the inability of the American system to control escalating health costs, the Canadian experience seems to offer itself as an attractive alternative for the Philippines. Of course there are a number of factors that could explain why the Canadians were able to institutionalize such a public insurance system. Significant among these is that the private, for-profit industry was less well developed and politically rooted in Canada at the time the crucial decisions were made. Thus, they were able to control global costs through the control of the costs of the insurance process itself as well as the cost of the provider of care (Evans, 1987: 121).

Although the differences between the Canadian and the Philippine setting must be noted, the use of power of the state is a promising variable which has not been given enough serious thought. The Canadian experience may have also been largely ignored because the Philippines has simply been more exposed to the American system.

To highlight the distinction between market-oriented and state-supported financing schemes, the discussion of HMOs and the alternative health care financing plans will be structured along two categories: those which benefit from open market competition (e.g. for profit HMOs) and those whose institution was prompted by non-profit consideration, e.g., employer-initiated, and consumer-based HMOs. Two alternative schemes where state participation is provided for: the pilot PMCC-HMO tie-up project and the Makati Health Plan will be discussed in Chapter VI.

### C. *Market vs. Public Provision*

Who should pay for what services in health care? What values should govern a society's decision in determining the amount to be spent on health, and the mode for distributing health services among its population? These are some of the central questions that continually beset health policy-makers. Where health resources are more scarce vis-a-vis growing demand and are also more inequitably distributed, the urgency of finding answers and the challenge of translating these answers to workable programs become more complex.

The growing literature in health economics and health financing attests to the range of ideas and concepts which have evolved in response to these policy dilemmas. More recently, the push for identifying alternative modes of financing has brought about the participation of international financial institutions like the World Bank and the Asian Development Bank. As these institutions assume a more active role in the search for alternatives, one witnesses a stronger push for market oriented strategies that seek to lessen government's burden and responsibility for funding health service from national budget.

Policy dilemmas in financing health services stem basically from the need to effect balance in the use of the market versus public provision such that an optimum mix is achieved in producing and distributing health care as a social service. Recalling the arguments for or against public provision of health care may be instructive at this point.

The market approach in producing and allocating health as an economic good is usually criticized on the following grounds:

- 1) Consumer of health services may not be rational in deciding on what health services to pay for since they may not have the information to decide what kind of services they will need.
- 2) The determination of what services the consumer needs is determined by the physician who also provides the service and thus has a financial interest in the transaction.
- 3) Providers may be organized as non-profit organizations and therefore are not propelled by the same motivations as for profit firms.
- 4) Consumers may be irreparably harmed by incompetent providers and therefore more stringent controls must be exercised in the provision of medical services.
- 5) Access to medical services is considered a right by society and its distribution cannot be left solely to the marketplace (Feldstein, 1983: 10-11).

Corollary to the view that health, as a state of complete physical, mental and social well-being, is a right, is the notion of "right to health care," which represents a concern for ensuring that everyone has a right of access to services and that this is an important normative goal of the health care system (Aday & Andersen, 1981:5). The fulfillment of these goals may be obviated in a market-oriented health delivery system since disparities in the distribution of income results in consumers' having differential access to scarce health resources and unequal health levels among consumers discriminate against high risk populations in the competition for health care services (Ellwood, et al., 1971: 297).

A society may decide that the state should provide some form of subsidy to redistribute health care along values which call for a) minimum provision, b) equal financial access, and c) equal treatment for equal needs. Minimum provision, as a value, will require that no person in society should receive less than a certain quantity of medical care in case of illness. Equal financial access to care, on the other hand, will mean that the price of medical care would be the same for everyone. To achieve equal treatment for equal needs, the health system must ensure equal consumption of medical services regardless of economic or other factors affecting utilization (Feldstein, 1981:526).

Advocates of the market or modified market approach for the production of health service have their counter arguments. The World Bank sees three main problems in government's attempt to finance full cost of health care from general public revenues. These are: 1) Misallocation of scarce government resources characterized by less spending on cost-effective health activities, 2) General inefficiency of public programs which translates into high and underfunded recurrent expenditures, low quality of public health services, drug shortages and deteriorated health facilities, and 3) Inequity in health services due to investment in expensive technology which serves the non-poor who have more access to these services and therefore pushes out the poor who then secure these services from the private sector at higher market prices (World Bank, 1987: 2-3).

Adherents of this view likewise contend that a large component of "free" public health services consist of expensive curative care and drugs which individuals are willing to pay for because they derive immediate personal benefits from their availment of these services. Citing evidence from selected countries' experiences that having to pay for services did not necessarily turn rural area residents away from these goods (ADB, et al., 1987: 119), the World Bank recommended the institution of charges for curative care and drugs in government facilities.

The imposition of user charges in government health facilities is just one aspect of a four pronged policy proposal through which the World Bank hopes to move public structures closer to a more market-oriented system. This set of complementary policy proposals include: a) instituting user fees in government facilities especially for drugs and curative care, using differential fees to protect the poor, b) providing insurance or other form of risk coverage, c) encouraging non-government providers to service consumers willing to pay for services and d) decentralizing financial decision-making processes for public health systems specifically those where user fees are charged and use market incentives to allocate resources (World Bank, 1987: 3-6).

These interventions are envisioned to trigger a series of processes and are complementary in that they rely on each other for positive effects. Since government charges for curative care, it must deliver quality service which is competitive in price and quality with private/non-government sector. To be able to pay for the prices of services which public and private hospitals set to recover costs and raise revenues,



the population must be insured or covered by risk sharing mechanisms. However, a health insurance scheme which will sustain an active, high quality private sector, will not thrive if free services are available at government facilities (World Bank, 1987: 7-8). Given the considerable influence the World Bank wields over a number of countries, its active advocacy of these policies has triggered financial reforms in at least nine countries (Jamaica, Thailand, Somalia, Zambia, Zimbabwe, Gambia, Peru, China and Brazil) (World Bank, 1987: 48). This development may signal the end of an era of the tradition that it is the state's responsibility to provide health care as a basic social service funded largely by taxes and at minimum or no out-of-pocket cost to the public.

These policy reform proposals are intended partly to deal with the developing countries' need to raise more resources for rapidly increasing health costs in the light of limited resources. Some more developed countries however, like Sweden, have succeeded in doing this with a small private health sector and where 85 percent of its health resources are spent in public institutions. Moreover, Sweden has also effectively dealt with problems of cost escalation. In his discussion of Sweden's experience, Jonsson pointed out that:

“expenditures during the last three years and of forecasts for the coming years clearly indicate that the growth of health care expenditure will decline even further. The projection for 1984-88 is that real cost will rise by 0.7% per year. In Sweden, the health care cost explosion is a historical phenomenon... An intense debate is in progress about the right mix of public and private sectors. There is obviously room for more competition and more private contractors, but changes in this direction will be marginal. It is therefore necessary to improve management within the public system... Sweden will probably choose a middle way, involving both market reform and improved health planning, for the development of health services” (WHO, 1987: 117).

This contention is supported by Blanpain who reported that an OECD 1982-83 health expenditure survey in industrial countries indicated that in Australia, Belgium, Canada, Finland, Norway and the United Kingdom, health expenditures as a percentage of gross national product have levelled off (WHO, 1987: 114). Reacting to the idea that Switzerland can better contain its health cost only through the competitive market, Blanpain suggested that price control, budgeting and cost sharing may be considered. The Canadian experience proved the value of budgeting as a cost-control mechanism, while in Belgium, health costs were controlled through price controls combined with utilization control and cost sharing (WHO, 1987: 114).

That market forces constitute only one option to promote efficiency is also stressed by Abel-Smith when he asserted: “A number of countries are deliberately planning to promote chosen priorities and greater efficiency- Finland, India, Israel and the United Kingdom, among them. Unlike the other countries,... the USA has had very limited success in containing health care costs and promoting efficiency; its current approach seems to be through market mechanisms as a possible means of achieving what other countries appear to be able to achieve by regulation and negotiation.” (WHO, 1987: 8).

Will efficiency and equity be attained through competition and incentives operating through market forces, or by more deliberate health planning and political will, or a combination of both? The answer will depend on the dynamics and conditions prevailing in each country. What is important to note is that there is empirical evidence to show that any one or a combination of these mechanisms deserves serious consideration. Consequently, policy-makers, administrators, and scholars in health in developing

countries must maintain an open but critical eye when they weigh the value and relevance of new ideas which they must examine in the light of the broader socio-economic and political conditions in their societies and the demands of national interest.

#### *D. Risk Sharing in Health Care Financing*

Regardless of how a country may decide to produce and distribute health services, risk sharing mechanisms have a role in generating more resources for health care services. The need to be protected from income loss due to sickness and from the high cost of medical care one will need at an unpredictable time of illness, is a common reason for seeking health insurance coverage. Akin explains the case for insurance or risk-coverage, thus: "Risk sharing is most valuable when the event insured against is largely unpredictable and the cost of the events' occurrence is large. The basic nature of any risk-sharing scheme is that small amounts of revenues are collected regularly from each participant, so that from the pooled funds, the large cost of the event insured against can be paid..." (ADB, 1987: 195).

Although unlikely and unpredictable, illnesses do afflict individuals at a rate where the risk of being sick cannot be easily dismissed. In the event one has the misfortune of suffering a serious illness, the cost of health services which can include physicians' fees, hospital charges, drugs, laboratory tests, etc. can be so large that it can cause serious financial hardship. To avoid having to pay the costs of a financially catastrophic illness, many individuals see the value of contributing an amount regularly to an insurance fund in exchange for protection for the risk of having to pay the cost of illness.

Thus, insurance and prepayments are forms of risk-transfer payment mechanisms: the individual who purchases insurance or enrolls in a prepaid plan transfers his risk to the insurance company or to the prepaid group (Berki, 1972: 155). Zschock sees as an essential element of risk-sharing schemes, whether public or private, a form of pre-payment or insurance principle that spreads the risk of incurring health care expenditures over large numbers of people. Thus, the consumer or the member of the plan is protected against the risk of having to make episodic, extraordinary expenditures for health care and hence the risk of being unable to obtain care (Russell and Zschock, 1986 : 63).

Social insurance, preferred providers (PPO), Health Maintenance Organizations (HMOs), cooperative schemes, employer or community based schemes and private insurance coverage are among the various forms of public and private risk-sharing arrangements through which financial risks are spread and possible alternative health care delivery systems may also be developed (de Feranti, 1985: 71-72; Russell and Zschock, 1986: 63).

As modes of raising and utilizing health finances, the risk sharing systems may influence the distribution of health resources and members' utilization of preventive or curative care as built-in incentives or disincentives may allow. De Feranti observes that these schemes may vary along four features: 1) nature of coverage, i.e. guaranteed eligibility at reduced or no additional cost, partial co-payment, additional fees to be assumed by a third party payor; 2) explicitness of risk-sharing, i.e. explicit (prepaid plans, HMOs) to implicit, i.e. employer provided health services, coop-provided services, 3) system of payment and collection, i.e., payroll deductions, insurance premiums, membership dues, coop share contributions, village assessments, and 4) distribution of risk among participants (de Feranti, 1985: 71; Russell & Zschock, 1986: 63).

Risk-sharing presents itself as a possible middleground between having to institute user charges and total reliance on taxes to finance public health systems. Its specific attraction as a financial scheme, however, derives directly from its stronger potential for equitably distributing the financial burdens for health care across the population covered. This equity-promoting feature of risk-sharing proceeds from cost sharing between those who become ill and those who remain well, while premiums, membership fees or coverage charges, can be graduated according to those who can afford to pay and those who cannot. Moreover, because of the smaller amounts contributed by members and the greater willingness to pay for protection, it is likely to succeed in raising substantial revenues. However, there is a basic disadvantage of risk-sharing mechanisms. They tend to foster overutilization of services. To avert this, de Ferranti cautions organizers of risk-sharing devices to undertake careful planning in establishing such scheme and more importantly, to complement the risk-sharing arrangement with some form of user charges to discourage over-utilization (WHO, 1987: 42).

Akin summarizes the efficiency, equity and revenue raising objectives of insurance and other risk sharing approaches, as: "1) Providing a service for which purchasers benefit and for which they are willing to pay (economic efficiency objective); 2) Providing for a fairer distribution of the society's cost of curative health care (equity case), and 3) Providing effective means for the collection of revenues for the curative health system." (ADB, 1987: 197-199).

Proponents of insurance and other risk sharing mechanisms as major sources of health financing do caution policy makers to the three common problems associated with these schemes, specifically the use of health insurance: a) administrative costs involved, b) incentives for overuse and c) incentives for provision of lower than optimal quality services (ADB, 1987: 201-203). Moreover, Abel Smith points out that contrary to its avowed objectives of equity and efficiency, health insurance can be socially divisive in that it will cover only those who are employed, located in urban areas and therefore are already advantaged by their having access to the more developed sectors. It also tends to favor men (as against women and children who may not be employed), curative rather than preventive and promotive services, and a marked preference for advanced technology in lieu of simpler and less costly modes of health service delivery (WHO, 1987: 59). In extracting lessons from the experience of developed nations, Mills lists five specific insights that can be drawn specifically from the American experience:

- 1) Insurance, because it lessens cost at the point of delivery, is likely to increase demand both for greater quantity of health services and for higher quality services.
- 2) While there is an expected correlation in the case of deductibles or co-insurance and reduced hospitalization, this correlation can be weakened by the extent of influence of providers.
- 3) If insurance agencies are unable to control the number of services used and their cost, the introduction or expansion of health insurance can lead to an appreciable rise in costs.
- 4) When insurance coverage favors in-patient services over out-patient care, it will bias treatment towards insured services.
- 5) The US experience demonstrates the complexity of the determinants underlying the demand and supply of medical care and the difficulties of either regulating or encouraging behavior in a market with strong vested interests (Lee and Mills, 1983:78).

How about other forms of private risk sharing mechanisms? What are the factors associated with the development of cooperative-based, employer-based or community based mechanisms?

Cooperative-based risk-sharing arrangements are more feasible in rural areas where the population is engaged in agriculture. One of the more popular cooperative-based experiences is that of the National Dairy Development Board program which started in the Kaira District Gujarat in India in the mid 1940s (NCIH, 1984: 2). It organized India's 10 million dairy farmers into viable cooperatives. When the cooperative felt the need for health services for its members in 1975, it created a charitable, non-profit making trust to provide basic prepaid health care to its members, especially for mothers and infants in the villages. The National Dairy Board experience demonstrates how cooperatives which tend to assume other service functions for their members had to create another foundation which provided health services to members within the cooperative structure (NCIH, 1984: 10-11).

At least three conditions need to exist before cooperatives may serve as a base for funding health services. These are: a) the existence of a stable and credible organization with long term viability, b) members' participation in frequent, regular transactions, and c) an administratively feasible way of setting aside a small portion of the product/cash exchanges which can in turn be used to fund health services. The health service may be directly provided by the cooperative or contracted to other providers (De Ferranti, 1985: 78-80).

Employer-based risk-sharing schemes usually refer to health coverage provided by employers for their employees, whether directly through the employee's own health facilities or indirectly through third party insurance (De Ferranti, 1985: 76). These schemes are similar to social insurance in that they provide services only for a select group of beneficiaries. While equity in terms of spreading health risks and with respect to income distribution may be met within the covered population, this may not hold in relation to the total national population. As a purely private sector activity however, it is quite different from social insurance. For one thing, it allows firms to choose among private providers. It also lessens the burden on the government budget and it presents opportunities for competition among other means of providing the same coverage. Drawbacks identified with employer-based schemes include limited coverage of dependents, possible duplication of services and problem in resource allocation from a social perspective (Russell and Zschock, 1986, 69-70).

Can emerging community-based prepayment schemes make a significant contribution to existing prepayment schemes? Stinson who reviewed more than 70 community self-financing efforts all over the world concludes that "community financing, at best, is just one element in a balanced financing approach. It does not pay for supervision, logistic support, or referral linkages and can be effective only if these services are financed from other sources." The communities usually cover cost of a) construction and maintenance of health posts, sanitation and physical facilities, b) providing community health workers and c) basic drugs. Moreover, three forms of inputs from outside the community are crucial: a major effort to promote community mobilization and liaison, technical and managerial assistance to individual communities and back up resources for temporary deficits (WHO, 1987: 97).

Doubts as to the adequacy and sustainability of community based financing schemes have been raised. It has been shown that community financing will rarely be sufficient to cover full cost of local services and that communities about to undertake such a scheme will require financial and organizational assistance during its start up and even operational phases (De Ferranti, 1985: 85-86).

### **III. Health Maintenance Organizations: Beginnings, Evolution and Experiences in Other Countries**

This chapter will define and delineate HMOs from other forms of health care financing schemes, identify the main types of HMOs and trace the beginnings of HMOs in the American setting. The experience of developing countries which adopted HMOs as a form of health care financing will also be discussed.

A form of risk-sharing mechanism that has evolved as a reaction to the increasing cost under the fee-for-service (FFS) delivery system and the negative effect of health insurance as a third party payment arrangement is the prepaid group practice, which is one form of contracting services among Health Maintenance Organizations or HMOs. This type of financing and delivering health services had as its predecessors the practice of European guilds, unions, churches and similar associations which collected small amounts from members and paid physicians who agreed to care for these members for a fixed fee, usually a capitation payment for so much members per unit of time. American firms, concerned for the health of their workers, made similar arrangements for their labor force in areas where physicians and facilities were few (Brown, 1983:32-33).

An organization's assuming responsibility for the financing and delivery of a set of health services is the hallmark of an HMO. It is essentially a formally organized system of health care delivery that combines the financing and provision of care to a defined population for a fixed prepaid fee. Payments made at regular intervals prior to need (prepayment) are made by consumers/members to cover the cost of health care. These payments are pooled by the HMO which prepares a budget to finance the health services needed by consumers. The health care costs of this group are then paid out of this pool. Since the pool finances health care for a consumer group which is diverse in health status and health care needs, the risk associated with the cost of care of any one person is spread across a large group. This pooled income also generates an enormous source of purchasing power for the HMO, which is exercised when it approaches selected physicians to serve the group. The HMOs generate a certain number of patients, a certain number of visits and thus a certain income level to physicians in return for their willingness to provide a discount on their fees (Cleland, 1984:6).

#### *A. Types of HMOs*

With whom and through what modes of payment HMOs arrange for physician's services for their members determine the distinguishing features of three main types of HMOs. In the first kind, the prepaid group practice (PGP), the HMO contracts with a single or multi-specialty medical group as a separate corporate entity to provide services to HMO members. The HMO compensates the medical group on a capitation basis. The PGP physicians practice out of a common facility, which facilitates cost and utilization control through centralization of services, the use of common support staff, and ongoing peer interaction. They pool their income as members of the group, distributing it among themselves according to an agreed plan (Falkson & Leavitt, 1981: 65; 1979: 75).

The second, the Individual Practice Association (IPA), type differs from the prepaid group in that the HMO contracts with the association, which in turn contracts with the physician to deliver services from their individual office practice. The IPA physicians continue to practice in solo settings, maintain their own offices and regular practice and usually are reimbursed on a fee-for-service basis, which may be about

10 percent or more below the prevailing rates. In the IPA, the physicians are almost always independent contractors and may devote only a small fraction of their time to prepaid patients (Brown, 1983:34; DHHS, OHMO, 1982: III-19; Goldberg and Greenberg, 1979:1021).

The third type is the staff model. Under this set up, full or part-time physicians and other health professionals are salaried or fee-for-time employees of the HMO and provide services to HMO members at an HMO facility subject to the prices and operational procedures of the HMO (Brown, 1982:34; DHHS, OHMO, 1982:III-19). In addition to their in-house staff, the HMOs may contract with external entities (referral service to specialist) to supplement their staff resources.

Actual HMO plans may combine some of the elements of these three types. What is significant is that an HMO is unlike the consumer-driven and more resource-constrained fee-for-service system which may exist along with government facilities. In this situation, the fee-for-service works for those who can afford to pay and seek the following benefits: no lines and delays in getting service; longer and more personal visits; and services that are generally available whenever desired (Cleland, 1984:4).

Figures 1 and 2 below are graphic presentations of how a consumer choice model where public and private sectors co-exist, differs from an HMO model where the doctor controls consumer use of the system.

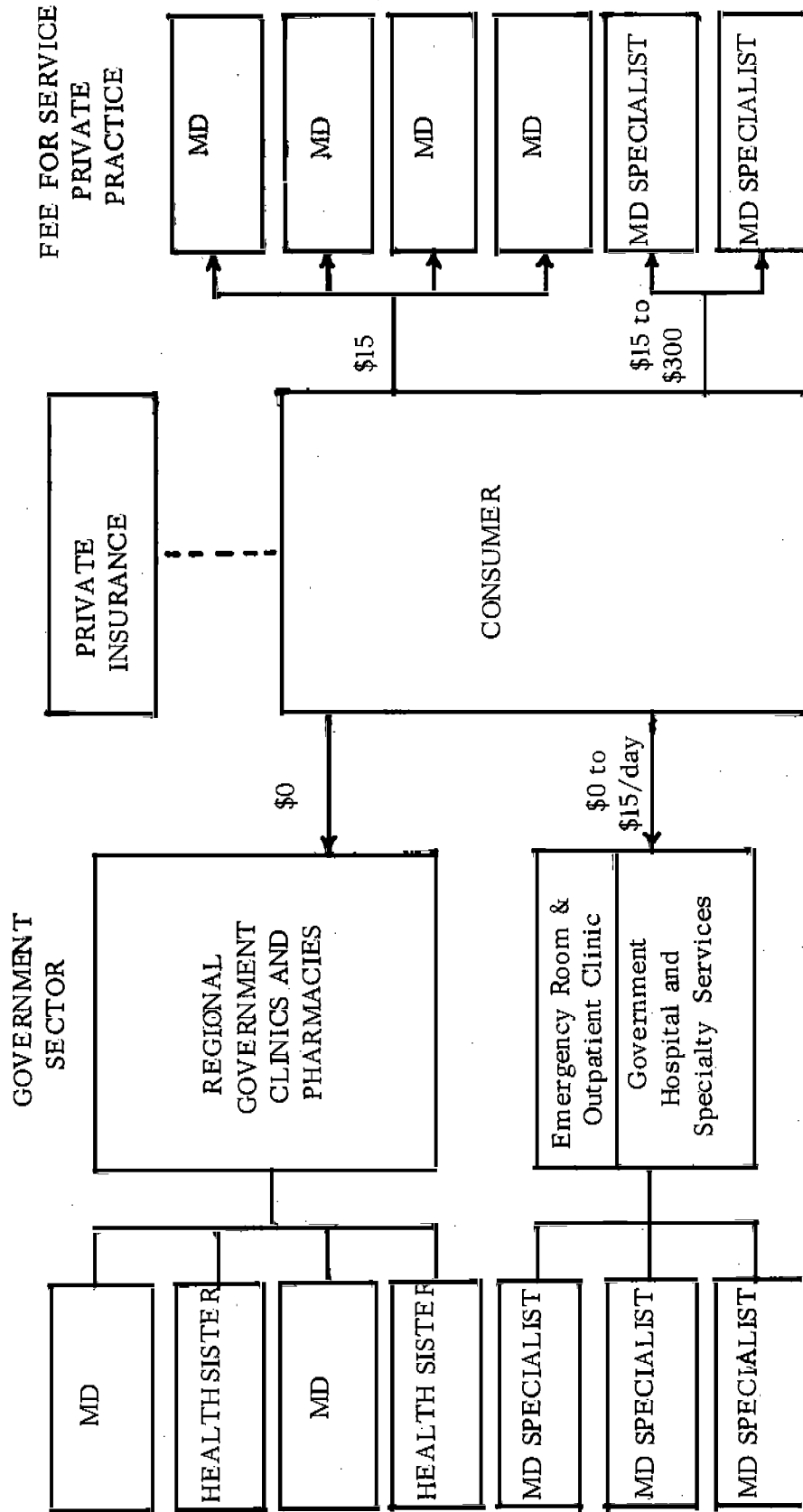
The first figure is essentially a consumer choice model in that the patient may choose any physician or hospital and may be served by that physician or hospital although both the physician or the hospital also has the option to refuse as there is no prior commitment to extend service to any patient. The patient is then charged for the service at the time of the visit, the charges vary according to the complexity of the service rendered. If the patient has a health insurance, the insurance company may reimburse the patient for the amount spent, deducting required co-payments defined under the insurance agreement. In this case, the insurance company is a third party payer who does not in any way affect the patient's choice of doctor or hospital (Cleland, 1984: 3-6).

Figure 2 depicts the HMO model where a consumer's choice of doctor or hospital is limited to those owned or contracted by the HMO to serve enrolled members. HMO staff or accredited doctors extend professional service to the member. The doctor could authorize hospitalization and monitor the same when necessary. Because the HMO system combines in the organization the delivery and financing of services, the end result is that health care providers are also at risk for the services they deliver, in that they may incur more costs than what they budgeted for given actuarial estimates for levels of utilization (Cleland, 1984:7).

The HMO varies from the traditional fee-for-service and health insurance system in that by combining the responsibility for health care delivery and financing in one institution, the end result is that health care providers are at risk for the services they deliver. Cleland elaborates further on how this is achieved:

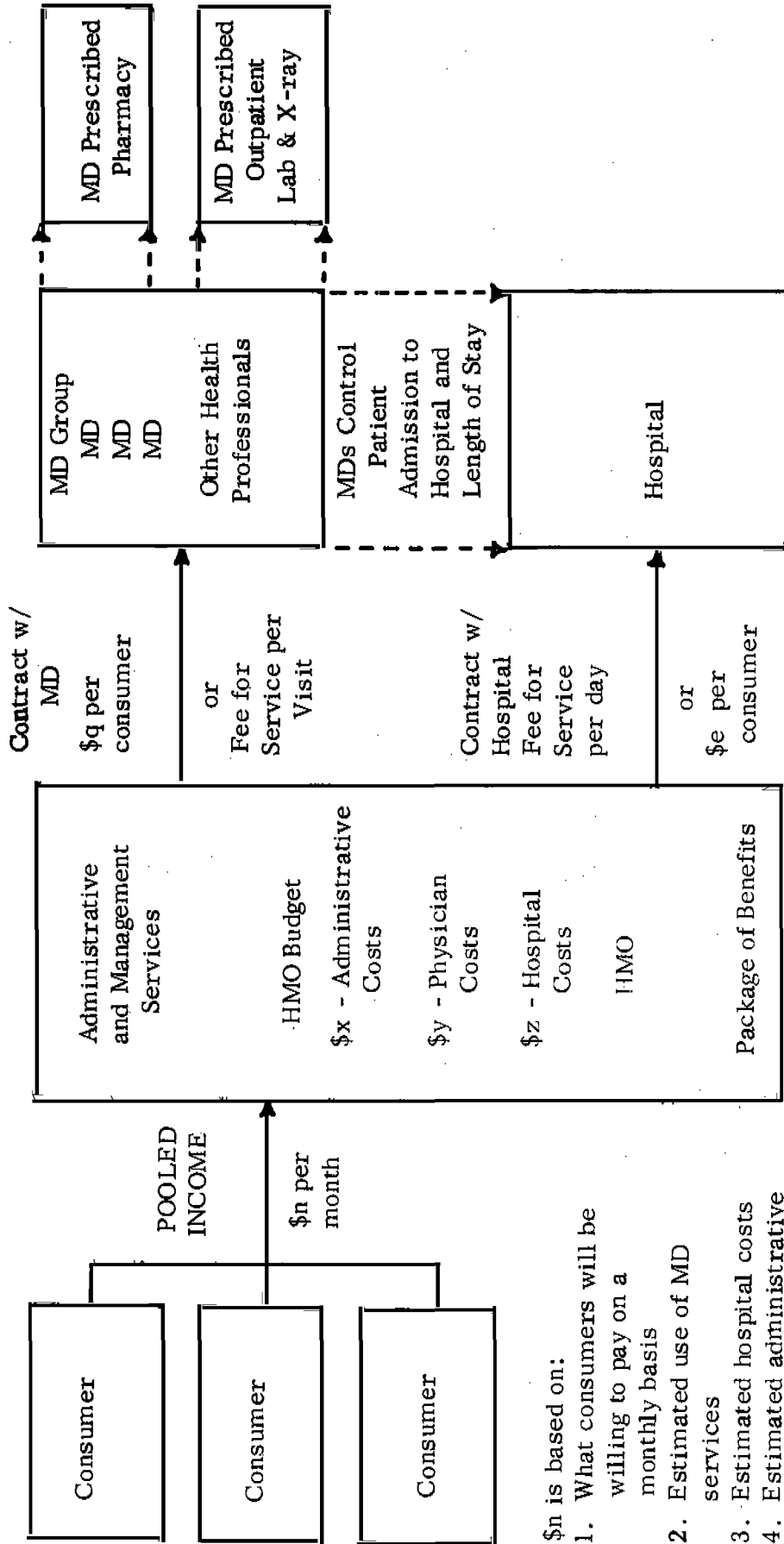
“With a given amount of money (the pooled income), the system is structured to assure that care is delivered in the most economical way to those that need it. Physicians participate in utilization control programs in order to derive economic benefits from efficient practice. In addition, it encourages early detection and treatment in order to avoid more costly spells of illness. If the

**Figure 1: Traditional System  
Consumer Choice Model : The Consumer Either Pays or Waits for Care at the Time of Illness**



ADAPTED FROM: Catherine Cleland, "Possibilities for HMO-Type Organizations in Less Developed Countries", (Office of Health Maintenance Organizations, Health Resources and Services Administration, DHHS, October, 1984), p. 3

**Figure 2: HMO Model  
MD Controls Consumer Use of the System**



Adapted from: Catherine Cleland, *op. cit.*, p. 5



budget is inadequate to pay for services, the physicians income is reduced. Waste is eliminated from the system through physician incentives, careful budgeting and control, and cost accounting procedure. *Since hospital costs account for the largest percentage of total health care cost, the physician incentives are tied directly to their ability to control hospital usage.*" (Cleland, 1984:7). italics supplied.

These characteristics of HMOs may suggest why in some instances, they are preferred over open-market, health insurance schemes. HMOs which finance and deliver health service themselves are clearly distinct from conventional insurance which generally provides reimbursement for the charges of physicians, hospitals and other providers of health care. Although the individual enrollees' choice of payments and other providers may be more limited than under conventional health insurance, the individual enrollee generally receives more health care service for his fees than are covered by most conventional health insurance programs. Under the conventional insurance systems, those who provide health care services are paid in direct proportion to the amount and complexity of the services actually provided. In contrast, HMOs receive the same amount from their enrollees regardless of the amount of service provided (NCIH, 1984:66).

HMO's opportunity to pool their incomes are noted to lead to four positive effects. First, since this income pool finances health care for a consumer group which is diverse in health status and health care needs, the risk associated with the cost of care of any one person is spread across a large group. If the prepayment is actuarially derived, the group pays for itself and will need little government support. Secondly it also generates a substantial source of purchasing power for the HMO which is exercised when it assures physicians of a certain level of income proceeding from a number of clients, in exchange for a discount on their fees, even as physicians are given the opportunity to earn more if they reduce the HMO's hospital costs through risk-sharing. Thirdly, HMOs can budget the cost of care, and finally extra revenues may be obtained for the system through short term investments because excess cash builds up due to the lag between the time service is rendered and bills are paid (Cleland, 1984: 6).

#### B. *The Development of HMOs in the U.S*

Paul M. Ellwood, Jr. is credited for having coined the term "Health Maintenance Organization." As the proponents of a U.S. Federal Government policy which would promote the development of health maintenance organization, Ellwood and his colleagues foresaw difficulties in continuing the Federal government's strategy in health as they argued that:

"The health industry is performing poorly because its structure and incentives do not encourage self regulation. Regulation of the health industry in its present form, at the very least, will require control of the price of professional services; the quantity of hospital services; the use of hospital services; the distribution and type of hospital facilities, including costly, high capacity components such as cobalt therapy or heart surgery units; the types, numbers and locations of professional personnel in at least 10 critical health professions and twenty medical specialties; the quality of services provided by more than 300,000 physicians. Regulation of such scope and complexity would be difficult...It is impossible...in a service industry in which professional judgment is required on the level of individual nurses or doctors dealing with individual patients." (Ellwood, et al. 1971: 292-293)

Five requirements were set as conditions under which the health maintenance strategy would result in improvements in the American health care market:

a) Health maintenance contracts would be awarded only to responsible organizations whose structures, resources and performance demonstrate the capacity to provide quality health services.

b) A performance reporting system of proven reliability would be developed and installed to provide both individual consumers and quantity buyers with accurate information on the comparative performance of alternate sources of health care. (HMO would be required to make such information available.)

c) To prevent discrimination against low income consumers, HMOs would be required to provide mandatory Medicare and Medicaid benefits at prices comparable to the traditional sources of health services. HMOs that wish to provide additional benefits could only do so on an optional basis to Medicare and Medicaid subscribers.

d) To avoid the possibility of creating separate medical care system for the old and the poor, health maintenance organizations would be required to also accept individuals who are not entitled to Medicare and Medicaid.

e) To protect against adverse selection, HMOs would be required to accept prospective consumers on a first-come first-served basis. Surveillance of the characteristics of populations served and services provided by HMOs would be maintained and if discrimination is evident, appropriate action could be taken against offending HMOs. (Ellwood, 1971: 297-298).

The U.S. Congress passed the Health Maintenance Act of 1973 (Public Law 93-222). Under this policy, an effort to encourage and stimulate the growth of HMOs led to the establishment of a federal grant and loan program. Since 1973, a number of HMOs were supported and developed through this mechanism. In its ten year report, the U.S. National Industry Council for HMO Development disclosed that a total investment of \$364 million - \$145 million in grants and \$219 million in loans - has generated 115 operational HMOs, or over 40 percent of the plans operational as of 1983 (National Industry Council for HMO Development, 1983: 7). The rate of HMO expansion is clearly indicated by the statistics. By the early eighties, there were about 323 HMOs in the U.S. which served 15 million members. Growing by 10% in 1983, membership is expected to approach 50 million by 1993 (Mayer, et al., 1985: 594). It has been observed that HMOs in the United States are products of an economic environment which has: (Ramey, 1984: 5-6)

- a) the largest middle class in the world
- b) a predominantly private sector based health care delivery system
- c) as a population, great elasticity in income
- d) a free enterprise based economic tradition
- e) economic resources which enable experimentation without irreversible consequences
- f) a long successful history of insurance indemnity-based programs
- g) a rigidly regulated health care service delivery environment
- h) a rigidly regulated investment environment.

A number of studies were undertaken to assess the performance of HMOs in the U.S. Some of them were done to check whether HMOs did in fact lead to more accessible, low cost and quality health service as they promised. The answer to the question, "Do HMOs save money," is quite clear. Luft contends that "a review of all substantial research on health care expenditure leads to the general conclusion that HMO enrollees have lower total expenditures for medical care (premium plus out of pocket expenditure) than comparable people with conventional insurance coverage" (Luft, 1983:322).

What about ambulatory care? The same study reports that when compared to people in conventional plans, a larger proportion of HMO enrollees have at least one visit per year. Hospital utilization data show that average differences in hospital utilization between HMO enrollees and people who rely on fee-for-service medical care are substantial, with about 30 percent fewer hospital days for PGP enrollees and 20 percent fewer days for IPA enrollees.

After examining a series of studies, Luft concludes that all the available published evidence indicates lower costs for enrollees in PGPs. These lower costs are not the outcome of substantial efficiencies in the production of specific medical services, such as hospital day or a physician office visit. Instead they are largely due to changes in the number and mix of services provided. Enrollees in both PGPs and IPAs experience somewhat more ambulatory or office visits than people with conventional coverage. This is largely a result of the better HMO coverage for such services and is reflected in a higher proportion of people in HMOs seeing a physician at least once a year.

The cost difference is due largely to hospital use. PGPs have markedly lower hospital admission rates while this difference is less clear in IPAs. The admission differences cannot be due to procedure categories nor to the increased emphasis in annual check ups and screening programs. There may also be some selection into PGPs by people who prefer less reliance on medical care even though they may be no healthier than their counterparts using conventional procedures (Luft, 1983: 327-28).

In so far as quality of service is concerned, Luft notes that while there is as yet no full resolution of the question, there is basis for a tentative rejection of the notion that HMOs reduce hospital utilization and achieve cost savings by offering substantially lower quality of care than the fee-for-service system (Luft, 1983:329).

Do HMOs in the U.S. meet the needs of the poor, the aged and the rural population? Luft's review did not lead to categorical answers to these questions. There is evidence which suggests that HMOs can enroll the poor and provide them with good quality care at reasonable cost. For the aged, there is a low participation rate since Medicare's complex reimbursement system serve as a disincentive for HMOs, who cannot attract Medicare beneficiaries through better coverage. In rural areas, on the other hand, the main problem is the availability and accessibility of health providers as these areas have the greatest difficulty attracting and retaining physicians. Moreover, for all the studies done on HMOs, little is known about the performance of different HMOs for financing and delivering medical care in rural areas (Luft, 1984: 339-340).

In their study on the economic performance of investor owned and non-profit HMOs, Schlesinger, et al. disclosed that investor-owned health care organizations have no inherent cost advantages over non-profit HMOs and may even be less efficient in certain settings. The contention that proprietary organizations will be better managed and therefore less costly was not supported by the findings of their

research. They see competition pushing HMOs to absorb their higher costs in the form of reduced profit margins or losses (Schlesinger, et al., 1986: 625-626).

In her assessment of the role and impact of HMOs in the over all cost containment effort of the U.S. since 1950 to 1985, Karen Davis noted:

“Health Maintenance Organizations have grown markedly in the last ten years... HMOs tend to grow more rapidly in geographic areas with high population mobility, younger families, and less strong ties with existing physicians... While HMOs have lower costs than traditional alternatives, the rate of increase in HMOs cost per person are quite similar to trends over time in the fee-for-service sector. *Therefore, it seems that HMOs are characterized as capable of achieving a one time downward shift in costs, but do not represent a permanent solution to slowing trends over time.* The HMO model has a potential for underservice since HMOs are paid the same rate regardless of how much care an individual patient receives. Abuses of patients have occurred in HMO settings and the potential for diminished quality is a genuine source of concern, particularly with the dramatic growth of for-profit owned HMOs. Federal qualification of HMOs should help reduce abuses, assure the financial soundness of HMOs and provide some check on quality” (Underscoring Supplied) (WHO, 1987: 82).

The Preferred Provider Organization (PPO) is viewed as a response of fee-for-service providers to the growing competition offered by HMOs. PPOs are hybrids of the payment method and practice mode adopted by the three HMO types. They combine elements of fee-for-service insurance with limited provider panels in which providers remain largely independent. While they are more like IPAs, they do not represent true HMOs. PPOs are different from HMOs in two ways: 1) they are not at risk for a defined population, and they retain the fee-for-service mode of payment and 2) consumers retain freedom of choice of physician, including non-PPO providers. Once PPOs operate as the exclusive provider to a defined enrollment and takes on the risk for expenses in excess of some predetermined level, it becomes an IPA (Hornbrook, et al., 1985:488).

Russell and Zschock see the PPO as an “indirect provider” type of prepaid health care organization. As an indirect provider, the PPO as an insurer negotiates arrangement with a group of providers (physicians and hospitals) for reimbursement of a fixed amount or fixed percentage of costs incurred. Those insured may be restricted to using only designated providers, or they may receive a higher reimbursement when they use the services of the preferred provider. While the insurer may or may not operate its own facilities, it does not assume responsibility for organizing and ensuring access to services (Russell and Zschock, 1986:64).

To what extent are the characteristics of the health care market in the U.S. parallel to those prevailing in most developing countries? Enthoven’s enumeration of the factors that account for the powerful growth of HMOs serves as good indicators of what economic or political conditions tend to be supportive of HMOs. He lists six conditions that may explain the accelerated growth of HMOs in the U.S. These are:

- 1) For multi specialty group practice HMOs, the margin of economic advantage over “guild free choice” and fee for service is large and growing.
- 2) While HMOs were suspected before of underserving their members, in recent years, employers have come to suspect the fee-for-service sector of overutilization.

3) There has been a breakdown in the political and economic power of the medical profession.

4) The increased supply of well trained group physicians has made it much easier for HMOs to recruit doctors while the fee-for-service sector is increasingly saturated.

5) There are more national HMOs (15) with the competence, personnel and management systems and the capital that allow them to enter more areas with confidence.

6) HMOs are becoming increasingly attractive to employees as employers are encouraging their employees to be more cost conscious (Enthoven, 1987: 247).

The remarkable rate of increase of HMOs and what Enthoven calls Competitive Medical Plans (CMP) is an outstanding feature of the movement of the U.S. health care economy into the market competition era with consumer satisfaction getting higher priority and HMOs accepting major responsibility for controlling the quality and total cost of health care (Enthoven, 1987: 249).

### C. *HMOs in Developing Countries*

What are the prospects for HMOs becoming prevalent in developing countries? It is estimated that between five and fifteen percent of the population of developing countries currently participate in some form of risk coverage for health care. More than half of those with risk coverage receive it through social insurance plans. The next most common source of risk protection are employer plans which provide care directly through employer-owned on-site health facilities. A few rely on outside providers or Health Maintenance Organizations (ADB, 1987: 193).

While they do not see any *a priori* reason why HMO may not succeed in developing countries, Andreano and Helminiak stress that what is valuable for these countries is the HMO concept rather than any specific design. Emphasizing the need to consider local conditions, they see the value of the HMO concept as providing a basis for establishing a financial arrangement, workable within specific economic realities prevailing in a developing country. A prominent characteristic of this arrangement is that it offers effective incentives to a provider organization extending comprehensive ambulatory and in-patient service in a cost effective manner. They likewise foresee two crucial factors that could affect the capacity of potential HMO arrangement to deliver what is desired: managerial expertise and the regulatory environment (ADB, 1987:265).

Using criteria which are likely to influence the feasibility of managed prepaid health care organizations, like strength of the private sector, availability of physicians and their attitudes toward prepaid organizations, the weakness or strength of the public sector delivery system, per capita income and the legal context, a Group Health Association of American (GHAA) 1985 study assessed the feasibility of prepaid plans in the Latin America and the Caribbean region (Russell and Zschock, 1986: 65). Russell and Zschock cited the GHAA report as having found the prospect as high for Mexico, Costa Rica, Panama and Brazil because of a sizeable population base and relatively high per capita income. Social insurance laws in Guatemala and Dominican Republic were structured in a way that they encourage private health care options. The relatively high urban income creates good prospects for prepaid services in Colombia. In Paraguay, Peru and Venezuela, prospects for managed prepaid health care were found moderately favorable. The small size of the middle class was the reason for the reservations in Paraguay while the reluctance or outright opposition to the prepaid concept on the part of the physician groups was another reason for the reservations for Peru and Venezuela (Russell and Zschock, 1986: 66).

The experiences in Latin America and the Caribbean suggest that legislation and government play key roles in determining the viability of HMOs. Legislation specific to HMO has been found to exist in Brazil, Chile and Uruguay. Government actions may also have negative effect on prepaid health plans. Some of these actions, including cuts in reimbursement, changing physician status vis-a-vis the HMOs, and higher premiums accompanied by a loss of buying power due to economic recession, have led to gradual disenrollment. Other factors such as absence of trained health care executors and low levels of education among the patient population have affected the expansion of HMO and have increased their financial risks. The financial position of prepaid health plans is another aspect of HMO operation that require attention (Russell and Zschock, 1984: 67).

The value of HMOs as alternative health financing schemes for developing countries stems from the nature of structural problems which confront the Third World's health care delivery system. Among others, these problems are 1) increasing cost of health care, 2) public sector's search for cost control and efficiency solutions through the private sector and 3) the need to address health care as a cost and productivity issue in business and the Third World (Ramey, 1984: 23).

However, even in the more developed countries, HMOs were not successful in providing service to a) the poor, b) rural areas and c) to areas where physicians and health providers are maldistributed (NCIH, 1984: 13-14).

To address these issues, proposals are offered as to how government can bring HMOs to those in lower income brackets. This would mean the government's:

- a) Instituting a reimbursement program where instead of the consumers, the government pays for the premiums and the government can make some of its facilities available to the HMO;
- b) Matching a trust fund set up by HMOs from its profits which can be used to subsidize premium payments from the lower union bracket; and
- c) Encouraging HMOs to offer a range of limited services to lower income groups for a lower premium (Ramey, 1984:47-48).

Another set of proposals directed towards the same objective include the government's:

- a) Purchasing a benefit policy from an existing HMO (or multiple HMOs) on behalf of lower income populations;
- b) Owning an HMO and designing its own economic incentives and risk sharing systems;
- c) Providing financial incentives to existing HMOs to service lower income groups; and
- d) Leasing health facilities to the HMO group, contracting on an incentive based approach (Russell and Zschock, 1984: 68).

#### IV. The Emergence of HMOs in the Philippines

This chapter describes and analyzes the national health situation, characterizes the national health care financing scene, and the magnitude and mode of health care financing. It likewise depicts the general features of HMOs in the Philippines and the environment within which they operate.

##### A. *The National Health Situation: A Brief Overview*

Filipinos born in 1989 are estimated to be able to live up to 62.2 years, for males, and 65.9 for females. Officially, the infant mortality rate was reported in 1988 as 30.1 per 1,000 live births. However, sources claim that the Department of Health is aware that this figure represents under-reporting and that the real infant mortality rate is closer to 51.5/1000 live births as of 1989 (Mike Tan, 1991:20).

Table 2 below presents the ten leading causes of morbidity and mortality. While acute bronchitis, diarrheal diseases, influenza, pneumonias and all forms of tuberculosis, are the top five causes of illness, pneumonias, diseases of the heart, diseases of the vascular system, all forms of tuberculosis and malignant neoplasms are the top five causes of death. The figures in this table show that over time, pneumonias and tuberculosis have consistently remained among the top killers. However, it is also important to note that when combined, diseases of the heart and the cardio vascular system have emerged as the leading cause of death in the country. Mike Tan attributes this to a combination of many different factors including increased stress, dietary changes, environmental pollution and smoking. Such problems are not necessarily signs of "development" but of continuing economic deprivation compounded by adverse effects of "modernization." Being chronic diseases, treatment can be inaccessible because of the expensive drugs required like anti-hypertensives such as beta-blockers (Mike Tan, 1991:33).

What facilities are available to Filipinos should they need medical services? As of 1987, there is a total of 1,799 hospitals in the country. Of this number, 590 or 33% are government hospitals while 1,209 or 67% are private hospitals. Between these two categories of hospitals, a total of 87,697 hospital beds are available all over the country (Philippine Yearbook, 1989: 308). Though government hospitals comprise only one third of the number of hospitals, they account for 53% of the total number of hospital beds with the private sector maintaining the remaining 47%. Government hospitals are more evenly distributed across the various provinces of the nation while private hospitals tend to converge in urban centers.

In terms of public health facilities and government medical workers, 1988 statistics reveal that the ratio of nutritionists to population is the lowest at 1:80,440, followed by dentists for which there is a ratio one for every 48,812 Filipinos and sanitary inspectors for which the public health system has one for every 28,856 population. The number of physicians, nurses and midwives per population reflects a more favorable picture. As of 1988, there is one midwife for every 5,663 citizens, one nurse for 4,716 and one physician for 6,184 Filipinos. Public health facilities figures show that there is one barangay health station for a population of 6,394 and one rural health center for every 28,340.

**Table 2: Ten Leading Causes of Morbidity and Mortality, 1988 (Rate/100,000)**

	<i>Morbidity</i>	<i>Rank</i>	<i>Mortality</i>	<i>Rank</i>
1. Acute Bronchitis	1,293.4	1		
2. Diarrheal Diseases	1,090.2	2	17.9	7
3. Influenza	981.6	3		
4. Pneumonias	343.8	4	80.8	1
5. Tuberculosis, all forms	311.8	5	46.0	4
6. Malaria	195.3	6		
7. Accidents	188.7	7	19.5	6
8. Diseases of the Heart	129.8	8	69.1	2
9. Measles	120.6	9	13.2	8
10. Malignant Neoplasms	49.3	10	36.1	5
11. Diseases of the Vascular System			53.7	3
12. Chronic Obstructive Pulmonary Disease			12.4	9
13. Respiratory Conditions of The Fetus & Newborn			10.9	10

Source: *Health Alert*, (April/May, 1991) pp. 17-18

#### B. *The Philippine Health Financing System: Essential Features*

The components of the Philippine health care financing system are shown in Figure 3. The interrelationship between consumers, financial intermediaries and providers as well as the flow of funds and services are graphically depicted in this figure. Consumers may avail themselves of public or personal health services. These may be paid for through individual or corporate taxes, insurance premiums, out of pocket payments, contributions and donations. From external sources, government may receive grants and loans or generate incomes through earnings of government health facilities.

The figure provides details on how the total system may be broken down into its component parts as follows:

1. Government funded Public Health Services (e.g., Maternal-Child Health Care, Immunization, Sewerage Disposal, etc.) and establishment, maintenance and operation of health facilities (e.g., hospitals, sanatoria, etc.)

2. Support subsidy via Medicare of personal health services provided by proprietary/private health facilities to government employees and their dependents.

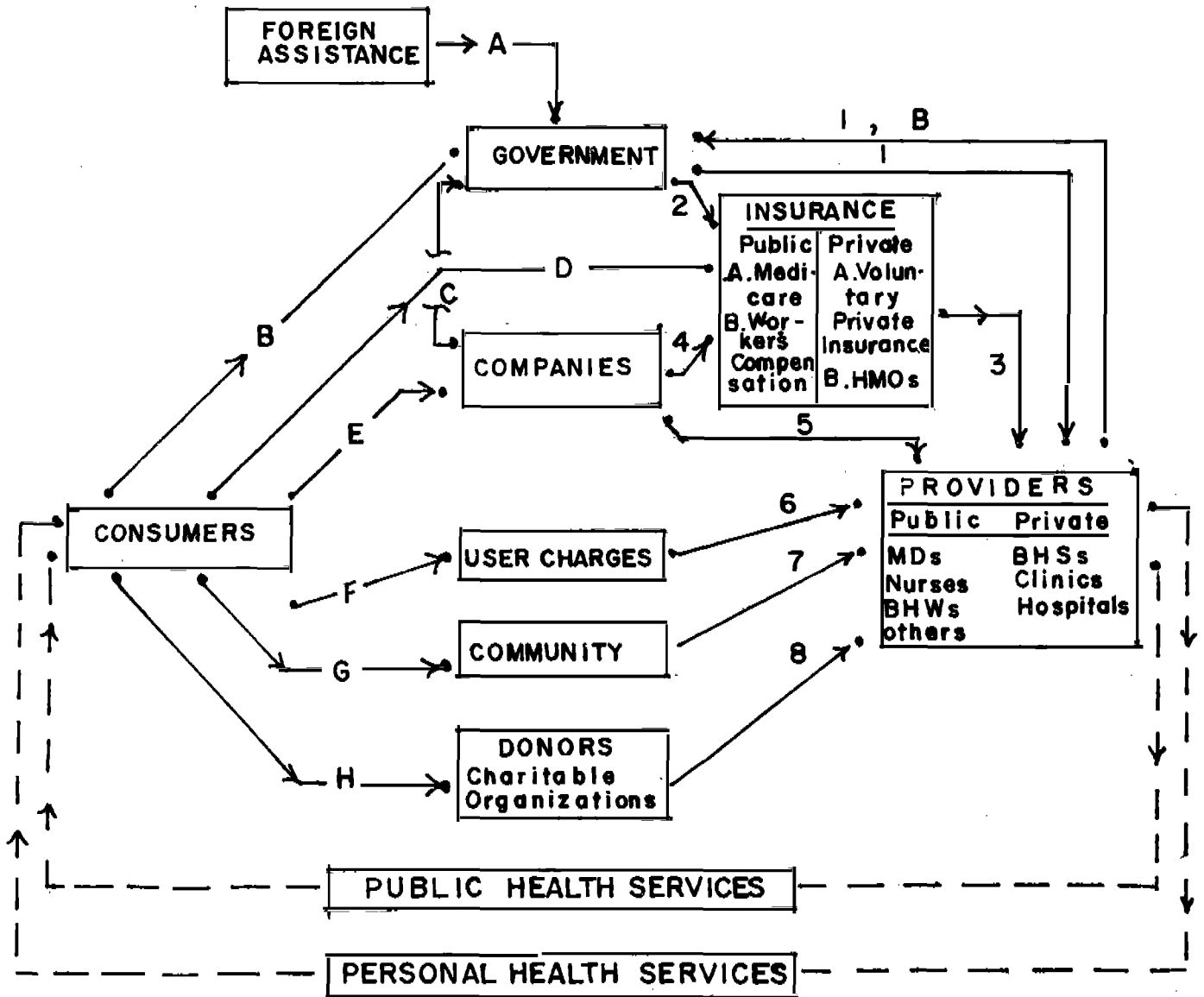
3. Payment for personal health services to subscribers/insured either directly to the providers or indirectly to the subscribers.

4. Contributions to Medicare and/or ECC as support subsidy for personal health services provided to employees and their dependents.

5. Payment for personal health services rendered to employees and their dependents by providers, and funding the establishment, maintenance and operation of health facilities that provide personal health services to employees and their dependents.



FIGURE 3: FLOW OF FUNDS AND SERVICES



LEGEND:

- A - GRANTS & LOANS
- B - INDIVIDUAL TAXES
- C - CORPORATE TAXES
- D - PREMIUMS
- E - LABOR EARNINGS
- F - OUT OF POCKET PAYMENTS
- G - CONTRIBUTIONS
- H - DONATIONS
- I - GOVERNMENT FACILITY EARNINGS

ADAPTED WITH REVISIONS FROM: INTERCARE, HEALTH CARE FINANCING IN THE PHILIPPINES; A COUNTRY STUDY (Manila, May 15, 1987), pp.16-17

"Insurance" and "Provider" boxes were disaggregated into "Public" and "Private" to show where HMOs may be located.

6. Direct payments, in cash or kind, to providers for personal health services.

7. Payment for specific components of personal health services, e.g., drugs, professional fees, hospital and other ancillary services, rendered to a member of a community who contributes and helps develop the Community Health Fund.

8. Support establishment, maintenance and operate health facilities to provide personal health services. Or finance other health services or components thereof (Intercare, 1987: 17).

It will be noted that HMOs constitute one alternative form of health care financing under the private sector. Providers are of three types; public, private and non-governmental institutions. Aside from transmitting government facility earning to government, private providers also pay individual and corporate taxes.

What are the essential features of this system in terms of the magnitude and modes of financing? What characteristics of this system have facilitated the development of HMOs?

One of the characteristic features of the Philippine health care delivery system is its reliance on two parallel sub-systems; the private and the public providers. The public health sub-system is funded and managed by the state and charges minimal, if any, fees for its services. The private sector consists of a network of providers and health facilities which function largely along market determined costs

The second feature of the Philippine health care system is the inequitable geographic distribution of health facilities and medical professions. Both tend to converge in urban centers where there is greater capacity to pay for the increasing cost of medical care.

A third characteristic of this system is reflected in Table 3 below which presents the 1987 National Health Survey results on percent distribution of households which have used specified health facilities during the past year, by income class.

**Table 3: Percent Distribution of Households Which Have Used Specified Health Facilities During The Past Year by Income Class**

Philippines, National Health Survey, 1987

Region/Income Class	All Households	Government Hospital	Private Hospital/Clinic
Philippines	10,756,579	32.2	34.1
Under 10,000	2,062,503	27.6	19.4
10,000-14,999	1,974,987	31.6	25.4
15,000-19,999	1,660,541	34.1	31.2
20,000-29,999	1,855,377	35.8	36.9
30,000-39,999	1,086,520	34.8	44.9
40,000-59,999	955,939	32.7	47.8
60,000 & over	1,139,388	30.1	54.3
Not Reported	21,324	50.4	27.0

Source: *Health Alert* (April/May 1991), p.74.

This table indicates that on the whole, among the respondents of the survey, about the same percentage of households utilize private and public hospitals. A closer scrutiny of the table will show an interesting pattern of more households utilizing private hospitals as their level of income increases.

A fourth feature of the system is its reliance on the fee- for-service mode of payment for the private sector even as different sources of funds for health care services may be mobilized i.e., individual and corporate taxes, grants and loans, insurance premiums, wages, out-of-pocket payment, contributions and donations.

### C. *Magnitudes and Modes of Health Care Financing*

How much is spent for health services in the country? Who tends to spend more and for what services?

In 1985, the only available estimate of the total health care expenditure in the country was that done by Intercare as part of an ADB commissioned country study on health care financing. The Intercare study then indicated that the Philippine total health care expenditures added up to 14.55 billion pesos, with the public sector accounting for 25% and the private sector for the greater part of 75%.

A recent reestimation of the magnitude of health expenditures for 1985 and 1988 using the Family Income and Expenditures Survey (FIES) has been done. This recomputation is part of an effort to update and validate the only known attempt to determine components of health expenditures by sources which was done by Intercare in 1985.

The outcome of the estimates of the magnitude of these health expenditures are presented in Table 4 below.

**Table 4 : Estimated Minimum Total Health Care Expenditures by Source  
1985 & 1988 ( in Billions of Pesos)**

	1985	%	1988	%
Government Health Care Expenditure	3,770	38	5,560	45
Private Health Care Expenditure	6,052	62	6,771	55
Total	9,822	100	12,331	100

Source: Orville Solon, Rhais M. Gamboa, *et al.* "Health Sector Financing in the Philippines"  
Vol.1 (RTI/UPSE, August. 1991), p. 16.

These estimates were computed utilizing figures on government's actual expenditures and estimated health expenditures of households using the FIES' percentage distribution of total annual family expenditures for medical care. Acknowledging the lack of reliable, complete and up-to-date data on private health care expenditure component on which to base accurate estimates of total (public plus private) health care expenditure in the Philippines, this recent work adopted a demand-side approach for estimation of private sector health expenditures. Using available demand-side data on the private health sector, this study made an estimate of the absolute minimum private sector health expenditures in 1985 and 1988 by

adding family health expenditures, adjusted compulsory health insurance benefits and private health insurance benefits (Solon, Gamboa, et al., 1991: 14). Payments made by HMOs and other pooled-risk programs and schemes, private employer-provided benefits, and health care payments made by PVOS, civic groups and philanthropic societies are excluded from these estimates.

A breakdown of the components of the aggregates for 1988 is presented in Table 5.

**Table 5 : Health Care Expenditures in the Philippines, 1988**  
(Billions of Pesos)

		1988	%
<b>I. Government Health Care Expenditures</b>		5.561	45
a. Taxes	5.40 (44%)		
b. Foreign Assistance	17 (1%)		
<b>II. Private Health Care Expenditure</b>		6.77	55
a. Family Spending	5.82 (47%)		
b. Private Insurance	.24 (2%)		
c. Compulsory Insurance	.71 (6%)		
<b>TOTAL</b>		12.33	100

Source: Solon, Gamboa, *et al.*, 1991:25

Data in this table will attest to the bigger share of the private sector vis-a-vis the public sector. Comparing 1985 and 1988 data using the same method of estimation would show a trend characterized by an increase in the state's contribution to total health care expenditures, even as the private sector continues to dominate.

The emergence of HMOs has been facilitated by a number of factors: 1) the decreasing buying power of the pesos over time, 2) the decreasing percentage of family expenditure devoted to health over time, 3) the increase in the price index of medical services and medicinal and pharmaceutical supplies by almost 400% and 4) the decrease in the support value of Medicare for hospitalization.

Table 6 in the next page indicates the erratic pattern of percentage distribution of total annual family expenditure for medical care. It shows that the highest percentage share of expenses for health was in 1957 when 2.4% of expenditure was spent for medical care. Except for 1985, when expenditures were higher compared to the previous year, from 1961, 1965, 1971, and 1988, total family expenditures on medical care tended to decrease relative to the previous year.

**Table 6 : Percentage Distribution of Total Annual Family Expenditure for Medical Care, 1957-1988**

<i>Year</i>	<i>% of Total Family Expenditures</i>
1957	2.4
1961	1.7
1965	1.7
1971	1.8
1985	2.1
1988	1.7

Source: *Philippine Healthcare Factbook*, 1990, pp. 77-82.

Even if the total family expenditures over the years would increase, the decrease in the percentage of expenditure allotted to health at the household level is substantial considering that the prices of medical services and medicinal and pharmaceutical supplies rose by almost 400 percentage points over the last 10 years. This is clearly shown in Table 7 below.

**Table 7 : Price Index of Medical Services and Medicinal and Pharmaceutical Supplies 1978-1988 (1978 = 100)**

<i>Year</i>	<i>Medical Services</i>	<i>Medicinal and Pharmaceutical Supplies</i>
1979	120.5	112.4
1980	148.6	129.1
1981	161.6	143.5
1982	186.0	158.2
1983	203.2	177.3
1984	264.7	275.2
1985	314.2	326.2
1986	335.4	365.3
1987	355.5	394.4
1988	376.8	420.2

Source: National Statistical Coordination Board, *1988 Compendium of Philippine Social Statistics*, 1990, pp. 59-60.

While government expenditures have increased in absolute terms from 1979 to 1988, this did not translate into greater magnitude of services for health. Table 8 in the next page shows that government expenditures as a percentage of GNP for these years were almost constant while health expenditures as a percentage of total government expenditures tended to decrease.

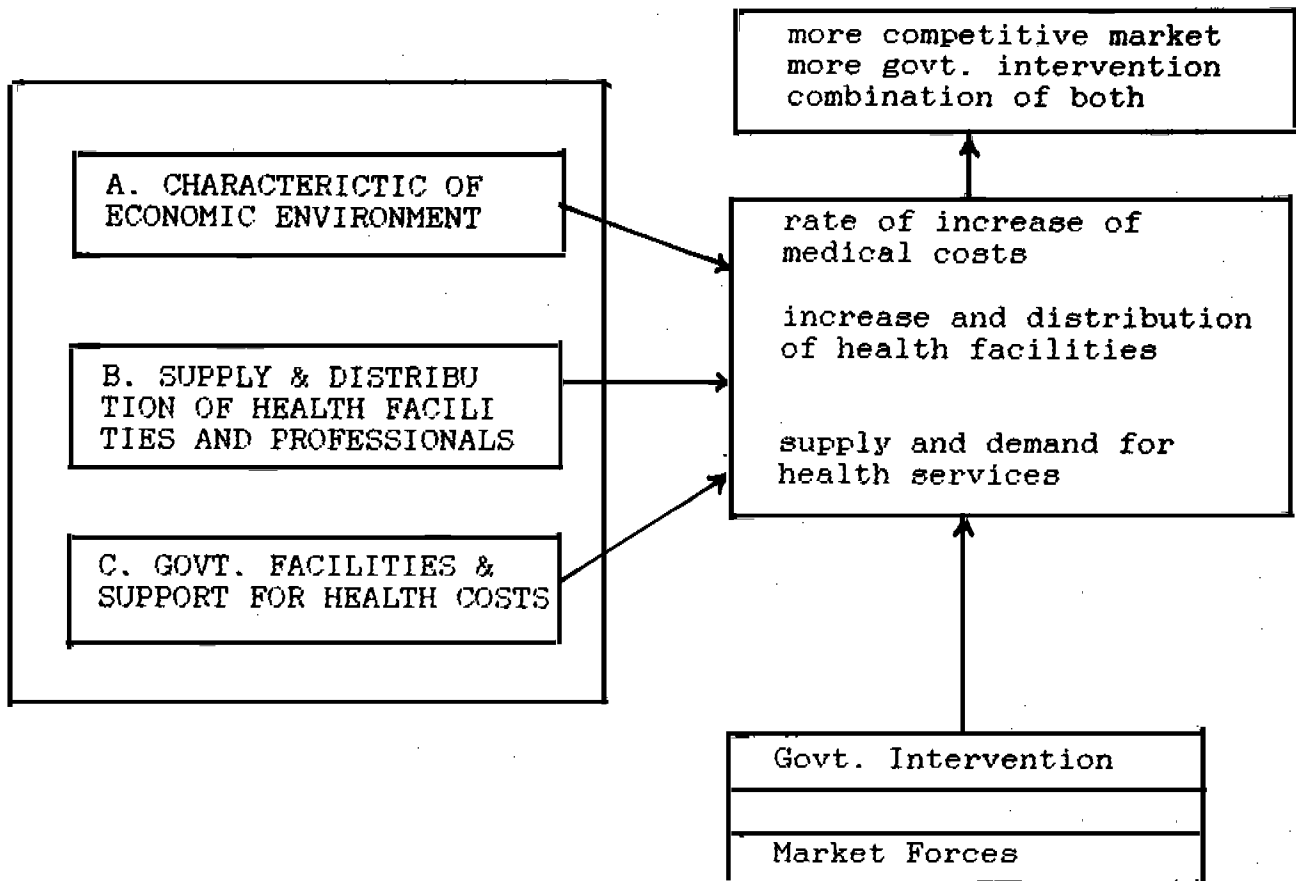
**Table 8: Government Health Expenditures as a Percentage to GNP,  
Total Government Expenditures and Social Development Expenditures  
1979 – 1988**

Year	Government Health Expenditures (Million Pesos)	Per Capita Expenditure (Pesos)	As a Percentage To		
			GNP	Total Government Expenditures	Social Development Expenditures
1979	1,672	35.5	0.7	3.7	17.5
1980	1,966	40.7	0.7	4.4	23.2
1981	1,977	39.9	0.6	3.6	20.6
1982	2,461	48.5	0.7	4.0	15.0
1983	3,181	61.1	0.8	4.6	17.9
1984	3,013	56.5	0.6	3.0	16.0
1985	3,666	67.1	0.6	3.6	15.3
1986	4,037	72.1	0.6	3.3	14.2
1987	4,671	81.4	0.7	2.8	15.4
1988	5,600	95.4	0.7	2.9	18.0

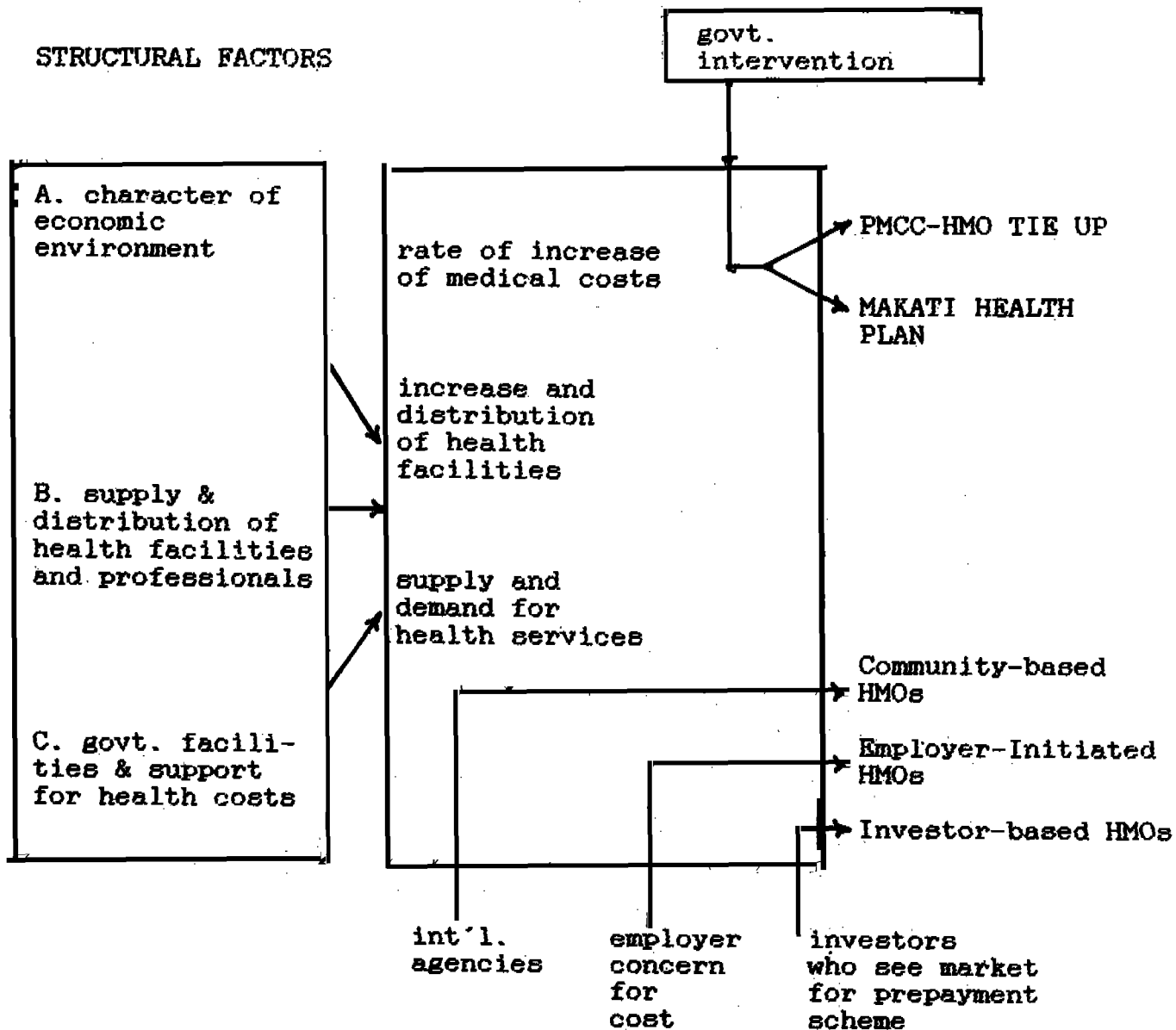
Source: National Statistical Coordination Board, "1988 Compendium of  
Philippine Social Statistics, 1990, p.215.

FIGURE 4

## FACTORS AFFECTING HEALTH SECTOR FINANCING



**FIGURE 5**  
**FACTORS AFFECTING EMERGENCE OF MARKET ORIENTED AND**  
**NON-MARKET ORIENTED HMOs/FINANCE SCHEMES**





The outcome of these declining levels of expenditures for health from the government and the individual side would put the Philippine in an unfavorable position vis-a-vis its ASEAN neighbors. While Singapore and Thailand had phenomenal growth in their per capita expenditures for health, the Philippine figure continues to decline as disclosed in Table 9 below.

**Table 9 : Per Capita Expenditure for Health in Asian Countries  
1978-1986 (In US \$)**

<i>Year</i>	<i>Brunei</i>	<i>Indonesia</i>	<i>Malaysia</i>	<i>Philippines</i>	<i>Singapore</i>	<i>Thailand</i>
1978	-	0.13	2.05	-	3.99	.83
1979	-	0.16	2.29	4.81	4.44	.83
1980	-	0.23	2.60	5.42	5.41	1.22
1981	-	0.30	3.00	5.05	6.75	1.47
1982	-	0.25	3.17	5.68	7.17	1.48
1983	-	2.29	2.90	5.49	21.20	18.15
1984	-	2.64	-	3.38	25.65	20.46
1985	-	3.14	-	3.61	26.72	23.89
1986	-	2.79	-	3.54	-	-
	- no data available					

Source: NSCB, *1988 Compendium of Social Statistics*, 1990, p. 72.

If households and the state have decreased their contribution to health care despite the declining power of the peso and the rapidly increasing prices for medical care, how has these affected the role of social or private insurance?

Table 10 shows that the country's Medicare program has expanded over a ten year period (1978-88) to cover 31.7 million persons, which is about 54% of the population. Of this number, GSIS takes 13.8% while SSS services 40.4%.

The actual contribution of Medicare to the volume of health resources as reflected in the estimates of the magnitude of total health care expenditure is 67% of the ₱ 725 M worth of money raised through insurance.

While the Medicare law stipulates that the program should cover about 70% of a member's hospitalization bill, the current program's support value is down to 31.5% of actual hospitalization cost. Depending on the type and ownership of hospitals, medicare support value may range from 25.8% (1987) to a high of 91.3% in a government primary hospital as presented in Table 11.

**Table 10 : Coverage of Medicare Program**

Year	Total	Number of Persons Covered ( In Thousand Persons)		Total	Percent of Population Covered	
		GSIS	SSS		GSIS	SSS
1978	14,722	3,622	11,100	32.2	8.0	24.2
1979	16,965	4,851	12,104	36.0	10.3	25.7
1980	17,548	4,332	13,216	36.3	9.0	27.4
1981	18,398	4,398	14,000	37.2	8.9	28.3
1982	19,536	4,728	14,808	38.5	9.3	29.2
1983	21,116	4,992	16,124	40.6	9.6	31.0
1984	27,394	6,509	20,885	51.3	12.2	39.1
1985	28,824	7,472	21,352	52.8	13.7	39.1
1986	29,514	7,179	22,335	52.7	12.8	39.9
1987	30,568	7,626	22,942	53.3	13.3	40.0
1988	31,714	8,091	23,623	54.0	13.8	40.2

Source: National Statistical Coordination Board, "1988 Compendium of Philippine Social Statistics, 1990, p.215.

**Table 11 : Support Values of the Medicare Program  
Selected Years With Type of Hospital and Ownership**

Year	Types of Hospital			Over-All Support Rate
	Primary	Secondary	Tertiary	
1981	48.38	33.8	23.6	39.8
1985	NA	NA	NA	31.5
1987	55.8	38.4	25.8	33.4
1989	66.2	46.1	45.8	48.9
Ownership Type*				
Private	64.3	40.4	33.9	41.4
Government	91.3	86.9	82.9	84.7
Over all	66.2	46.1	45.8	48.9

\*1989 Experience

Source: Rhais M. Gamboa, "Background Paper on Health Insurance in the Philippines" (Draft Report, May, 1991) p. 114.

In summary, the health care financing scene in the Philippines is one which mirrors the a) status of the economy as reflected in the indicators of the economic environment, b) the inequitous distribution of health facilities and professionals and c) the decreasing state expenditures for health services. These general conditions have been influenced further by the rapidly increasing cost of medical services, the increase of health facilities and the supply and demand for health services, as shown in Figure 4 below. Depending on how the government or market forces will intervene in the interplay of these factors, the resulting roles of competition, state intervention or the combination of both in the allocation and production of health resources may be affected accordingly.

The need for prepaid, managed health care was felt by those with fixed earnings and some surplus which they can use or set aside for their future health needs. This need was triggered by the rapid rate of increase of medical cost which was growing faster than the rate of increase of income. Moreover, the government's social insurance program had such a low support value that it barely protected members from the risks of incurring huge bills when they need hospitalization.

*D. General Features of HMOs in the Philippines*

In its 1987 report, Intercare described the status of HMOs in the Philippines, thus:

"HMOs in the Philippines are relatively young and are still in their early beginnings. Enrollment is less than 1% of the population and the concept is not yet well appreciated by the average Filipino. HMOs differ from insurance in that they combine management of health care with its financing. It provides an automatic brake on overutilization of higher cost health care and gives incentives

for utilization of cost effective health care. There is as yet, however, no *genuine* HMO operating its own health facility in the Philippines because of capital constraints and limited market base. (underscoring supplied)

Must an HMO operate its own health facility before it can be considered "genuine"? Are all others operating without their own health facility not genuine? The absence of a clear acceptable framework which could serve as a benchmark against which the operation of a Philippine HMO may be assessed as "genuine" or "legitimate" has resulted in the use of different notions as a basis for determining when the combination of a financing and a health care delivery system results in an institution which can be properly called a Health Maintenance Organization.

This study favors the use of Luft's definition of an HMO as a system of health care that combines the delivery and financing of service in that it:

"a) Assumes a contractual responsibility to provide or ensure the delivery of a stated range of health service, including at least physician and hospital services; b) Services an enrolled, defined population; c) Has voluntary enrollment of subscribers; d) Requires a fixed periodic payment to the organization that is independent of use of services; and e) Assumes at least part of the financial risk and/or gain in the provision of services(Luft, 1980: 503).

Closer scrutiny of the articles of incorporations of corporations operating as HMOs in the Metro Manila area will show that a statement of the primary purpose commonly found is quite broad and read, thus:

"To engage in the business of developing, conducting, maintaining, arranging for and promoting comprehensive medical and health maintenance services and for the implementation of said objective, to put up, establish, construct, organize and equip and/or accredit, contract and enter into agreement with medical clinics, hospitals and other medical establishments as well as duly licensed physicians, surgeons and/or persons with specific medical specialties for the delivery of said services."

Using this feature and the elements identified in the Luft definition, how many and what kind of HMOs do we see in the Metro Manila area? Different sources give varying figures. The Solari report (Solari, 1988: 11) mentions twelve (12), even as it qualifies that there are more coming into the market. A newspaper article mentioned a range of "12 to 26 HMOs" (Daily Globe, April 23, 1989: 9, 18), while a special supplement of another daily cites the president of the Association of the Health Maintenance Organization of the Philippines (AHMOPI) in his estimate of twelve to fourteen HMOs (Philippine Daily Inquirer, April 15, 1988: 17).

This study has identified a total of nineteen (19) HMOs broken down into three categories as follows: a) sixteen (16) investor-based or "for profit" HMOs, b) two (2) consumer-based HMOs being piloted through a USAID/PCHRD supported research grant and c) an employer initiated HMO (PAL Dependents Medical Plan). (See Annex 1 for a directory of these HMOs.) The operation of these three types of HMOs varies according to their nature and objectives. For this reason, each HMO type will be discussed separately.

### E. *The Unregulated Environment of HMOs*

As corporations, HMOs must register with the Securities and Exchange Commission (SEC). However, as an emerging mode of financing and delivering health care services, the financial viability of organizations rendering such service and the adequacy or quality of the services rendered are not monitored nor regulated by any government agency such as the SEC, the Office of the Insurance Commission (OIC) nor of the Department of Health. Considering that HMOs collect regular payments in lieu of a promise to deliver a package of services, it is curious why HMOs are not covered by any existing government policy or requirements as to how they can assure members that their financial contributions are well managed such that these members' medical claims can be adequately provided at the time of need.

Why is this the case? The absence of a clear policy on HMOs may be attributed simply to the fact that these organizations are relatively little known, new phenomena in the health care financing scene, possessing the characteristics of, but quite different from, private health insurance covering individuals or groups. As a hybrid which combines some of the features of the fee-for-service mode of delivering health care and the prepaid character of health insurance, HMOs do not fit in any of the existing categories of corporations covered by existing laws implemented either by the Securities and Exchange Commission or by the Insurance Commission.

Thus, in response to a formal query from this researcher, the Insurance Commission replied that "... this Commission has no jurisdiction and/or supervision over Health Maintenance Organizations, popularly known as HMOs. Ours is limited to insurance companies and parties engaged in insurance activities as the provisions of the Insurance Code do not contemplate the organization and operation of HMOs" (OIC Letter dated December 16, 1988).

The Securities and Exchange Commission, on the other hand, is of the position that it may not supervise these companies since they are not involved in the sales of securities.

The OIC does not cover HMOs as the latter can not fall within the rubric of "insurance activities" since there is no predetermined amount set for the value of the services as in the case of an insurance policy. Nor can an HMO be categorized as a kind of a pre-need plan which has been defined by the SEC as "a contract which provides for the payment and/or performance of future service or services at a fix value at time of actual need, payable in cash or installment by investors at a stated price with or without interest or finance charges and with or without insurance coverage (SEC Bulletin, No.2 Series of 1984).

The Department of Health has not assumed the responsibility for regulating the delivery of health services being undertaken by HMOs either. This is principally due to the perception of some ranking officials of the Department that the DOH does not have the institutional capacity to assume responsibility for monitoring or regulating HMO activities.

As a result of all these, there is no government agency which is responsible for the enunciation of a government policy on HMOs. Thus, no government agency has administrative jurisdiction over any complaint or grievance against an HMO. Any aggrieved party who would want to air their complaints for purposes of seeking redress for these grievances must formally file a case before a court.

Basically, goods and services are produced and distributed in the country through mechanisms of the free market where open competition, functioning through the price system, is expected to enhance individual's welfare and produce efficient results as well. Theoretically, the idea of a perfectly competitive market is sound. In reality, markets do not function under conditions of perfect competition most of the time. When, for a number of reasons, markets fail, the government may come in to protect national interest. Stokey and Zeckhauser offered two compelling reasons for government to participate in the resource allocation processing of society. These are when the state seeks to advance equity, through which a more desirable distribution of goods and services in society is fostered, and efficiency which is promoted in situation where the market has failed (Stokey and Zeckhauser, 1978: 253).

Market failure may be due to a number of factors, including:

1. Information is not shared costlessly among all prospective participants in the market.
2. Transaction costs significantly impede the conduct of beneficial trades.
3. The relevant markets do not exist.
4. Some of the participants in the market exercise power.
5. Externalities are present so that the action of an individual (whether firms or an organization) affect the welfare of others.
6. The commodity involved in the policy choice is a public good (Stokey and Zeckhauser, 1978: 322).

In the event government has to intervene to supplement market forces it may decide to take any of the following options: a) It can attempt to improve the working of the market; b) It can require individuals and firms to behave in specified ways; c) It can provide incentives that influence the decisions of private individuals and firms; and d) It can engage directly in the provision of goods and services (Stokey and Zeckhauser, 1978: 310).

Policymakers in both houses of Congress have taken interest in the role of the HMOs in financing and delivering health services in the country. In the Senate, a resolution (Senate Resolution No. 425) directed the Senate Committee on Health to look into practices, program, policies, procedures and government supervision of HMOs. Noting with concern the absence of government protection for HMO members, this resolution directs attention to the fact that HMOs are not subject to requirements like minimum paid up capital, margin of solvency, inspection and audit, annual reporting and prior approval of contract wordings (*Daily Globe*, May 1, 1989: 3). In the Lower House, the Chairman of the House Committee on Health has formally filed House Bill No. 16185 which seeks to revise the Philippine Medicare Law and establish a national non-profit Health Maintenance Organization system. To date, none of these initiatives have led to major policy decisions on government-HMO relations.

DOH consultants hired to look at PMCC and HMOs operations have consistently recommended government regulation of the latter. In his February, 1988 report, Alfredo Solari saw the need for government intervention on definition of HMOs, the need for licensing, establishing a benefit package and enrollment practices and the provision on pre-existing conditions (Solari, 1988: 19-20).

Two years later, Roger Day, another consultant, wrote in his report that while a majority of those whom he interviewed believed that HMOs should be regulated, there was no clear consensus on a single most appropriate unregulatory body or on primary regulatory priorities.

He also observed:

“The greatest consensus noted was on the desirability of some solvency regulation and establishment of mechanisms to reduce and resolve consumer complaints about service availability and provider complaints about authorization for treatment and timely payment.

Mr. Day recommends a four pronged, multi-tiered approach to HMO policy development and regulation with the following features:

- 1) PMCC certification should continue for the enrollment of Medicare and GSIS beneficiaries, to promote HMO growth and development and to create incentives for managed care operations;
- 2) An Interagency Commission with representatives from the Insurance Commission, the Department of Health and the PMCC should meet with an HMO Industry Advisory Committee to consider core regulatory priorities. Initial core regulatory measures should be enacted to protect existing HMO enrollees in the event of an HMO insolvency;
- 3) Other regulatory requirements which would be useful in protecting the public interest affected by HMO development should be phased-in; and
- 4) Consideration should be given to establishment of a Special Commission on Managed Care to discuss and recommend longer term HMO policy” (Day,1990: 7-8).

The third consultant, Dr. James Jeffers in his June 1990 report had this to say:

“...in the ROP (Rep. of the Phil.) HMOs are operating with questionable legal sanction, and are virtually unregulated. Since these organizations collect money from subscribers who depend on these organizations to provide for the provision of services when they become ill, the possible business failure of HMOs is a serious matter. It can be argued persuasively that HMOs are risk bearing and fiduciary agencies, and thus in addition to certification as to the quality and standard of medical services likely to be rendered, they should be regulated like insurance companies in terms of requirements to maintain a proper capital structure, management standard and practice proper composition of the board of directors, all in the interests of protecting the interests of the general public would appear to be desirable, if not imperative” (Jeffers,1990:10).

As the number of HMOs and their membership grow, the requirements for the efficient operation of market forces begin to take a more definite form. Prospective members begin to clamor for more information on HMOs' performance as a basis for choosing among their competitors in the market. These members also feel that there is a need for an entity which can protect them from unethical practices of irresponsible business firms who may deliberately mislead people into buying a product they are not familiar with. Under this condition, market forces can not ensure efficiency nor the maximization of individual welfare. Government clearly has a role to play in setting the stage for a better flow of information or to require HMOs and their members to behave in specific ways. There are a number of options. Among these options is the proposal of the Association of Health Maintenance Organization of the Philippines or the AHMOPI, to leave self regulation to the association.

*The AHMOPI and Self-Regulation* In 1987, six of the top HMOs constituted the Association of Health Maintenance Organization of the Philippines or the AHMOPI. The association's primary objective was “to unify all health maintenance organizations and other companies similarly engaged in the prepared

health care business throughout the Philippines in an effort to effectively rationalize the HMO/prepaid health care business in terms of operating standards mutually acceptable and beneficial to each member company." Noteworthy among the AHMOPI secondary objectives are their intentions to: 1) Undertake appropriate steps in attaining proper recognition of the HMO/pre-paid health care business as a distinct and important sub-sector in the health care industry; 2) Establish minimum standards for the proper delivery of health care services to the target beneficiaries/HMO members; 3) Establish and maintain linkages with various government agencies, i.e., Department of Health, regulatory bodies, etc., 4) Provide a feedback mechanism to various industry proposals or guidelines which can be the basis for the enactment of laws and regulations for the HMO/health care industry; 5) Formulate and adopt norms of conduct within the association to ensure that all member companies observe ethical standards in all areas of the business, particularly in the marketing and the delivery of medical services; 6) Provide a form of exchange of non-confidential information among member companies for the purpose of adopting mutually acceptable minimum standards in the industry. (Articles of Incorporation, Association of Health Maintenance Organization of the Philippines).

In the same article of incorporation, the association defines an HMO company as one "basically engaged in the business of prepaid membership in a health care delivery system which provides comprehensive, diagnostic, preventive and curative services or procedures as prescribed by the medical provider at accredited hospitals or clinics based on stipulated provisions of the member's Service Agreement/Contract." Five main attributes of an HMO are then enumerated as:

- 1) It is a duly recognized and registered company (corporation or partnership) with viable funding and resources committed to the delivery of health care services;
- 2) It has efficient medical service facilities, i.e., hospitals, clinics, or medical center which have been contracted or accredited to provide such facilities to the HMO company;
- 3) It has a team or teams of medical providers (i.e. a group of medical and allied health care professionals/practitioners) in each accredited/owned hospital, clinic or medical center who have a contractual responsibility with the management of the HMO company;
- 4) It has a viable membership level or beneficiaries whether individual, families, group or companies/institutions.
- 5) It has a prepayment mechanism that is defined in terms of the amount of membership fee and payment frequency for a specific period of time (Articles of Incorporation, AHMOPI).

These elements are basically in keeping with the elements of an HMO as theoretically defined in this study.

The capacity of an association like the AHMOPI to exercise self-regulation in the industry is limited by the fact that not all the 16 investor-based HMOs identified in this study are members of this association. Assuming that this self-regulation mechanism can set and enforce a code of ethics which will govern the marketing and provision of health services, the association can deal only with its members. Who will then take care of the other non-member HMOs? What does the existence of an association of less than half of its prospective members imply for the industry as a whole? The AHMOPI has articulated its need to be formally recognized by the Philippine government. In view of the absence of a formal government policy towards HMOs as an industry, will the government's recognition of the AHMOPI mean that the association can now regulate itself?



Self-regulation among HMOs is not feasible. It is precisely this inherent inability of the health industry to regulate itself that prompted the adoption of the health maintenance strategy in the U.S. HMOs were organized to "promote a highly diversified pluralistic and competitive health industry." As discussed earlier, Ellwood pointed out that the health industry in the U.S. is not performing well because its structures and incentives do not encourage self-regulation. Regulation of the health industry in its present form in the U.S. was considered difficult because it is a service industry in which professional judgment is required on the levels of individual nurses or doctors dealing with individual patients. While this argument was based on an assessment of the American health industry, the same can be said of investor-based HMOs in the Philippines where the fee-for-service system operates along the same lines as those in the U.S.

A newspaper item titled "HMOs favor self-regulation" (Manila Bulletin; July 10, 1989: 36) indicate that the association of Health Maintenance Organizations argue that instead of regulation, the government can establish an accreditation system for HMOs and leave the task of regulation to the association. They likewise ask that the government provides them with incentive packages like tax holidays and subsidies which is being done in the U.S.

To use the American experience as a model of how the Philippine government should define the role of and support HMOs in the health financing scheme in the Philippines would be inappropriate and unwise. For one thing, a close look at the American experience will show that, unlike in the Philippines where for profit HMOs dominated the industry even at its early stage, in the U.S., the early HMOs were non-profit agencies and it was not until the eighties when for profit HMOs evolved as areas for investment in the U.S. U.S. Public Law 93-222, the Health Maintenance Organization Act, provided financial incentives only for non-profit HMOs. Perhaps the appropriate advice on this question is that of Mills who aptly remarked that "any attempt to relate American experience to developing countries must clearly take into account the differences in their levels of health and health care expenditure." (Lee and Mills, 1983: 78). Moreover, the operation and size of the American economy differ markedly from those of the Philippine economy where the public sector must continuously struggle with extreme scarcity of resources in the face of growing demand.

## V. Investor-Based HMOs

Investor-based HMOs constitute the single biggest group and dominates the market. In fact, it is the more popular kind among companies and consumer in the Metro Manila area. This chapter dwells on the emergence and operations of profit-oriented HMOs with particular emphasis on HMOs marketing their plans in Metro Manila and other urban centers of the country.

*Date of Incorporation and "Parent" Company.* Table 12 lists these 16 HMOs and gives their dates of incorporation (when new corporations were set up), when they started operations, and the nature of business of their "parent" or sponsoring companies. That this industry is in an incipient stage is quite evident in the dates given in this table. The only one incorporated in the late seventies was Intercare. This pioneer in developing a health care system originally used a preferred provider form but eventually evolved as an HMO-like structure for the Canlubang Sugar Estate in 1974. Almost all of the other companies were organized in the early or mid-eighties. Four companies were affiliated with insurance firms, while six are associated either with a clinic or a hospital. Four of these HMOs had their beginnings as industrial clinics

**Table 12: Premium Rates and Maximum Benefits**

TYPE OF PLAN	ST. VINCENT as of July 1, 1987			BLUE CROSS as of Jan. 1989			
	Ward P 150/day	Semi-Private P 250/day	Private P 300/day	Ward P 120/day	Semi-Private P 200/day	Private P 400/day	Suite P 600/day
<b>I. INDIVIDUAL</b>							
Annual	775	996	1107	993.6	1104	1600.	2815.
Semi-Annual	405	520	578	518.4	576	835.2	1468.
Quarterly	207	266	296	264.6	294	426.3	749.7
Monthly	70	90	105	90	100	145	255
<b>II. FAMILY</b>							
Annual	4095	5176	5812	5244	5796	8533.	14937
Semi-Annual	2140	2690	3038	2736	3024	4452.	7922.
Quarterly	1092	1376	1551	1396.	1543.	2272.	3977.
Monthly	370	465	525	475	525	773	1353
<b>III. GROUP/CORPORATE</b> (per member)				min. of 20			
<b>ANNUAL</b>							
Principal				717.6	794.8	1159.	2042.
Dependent							
<b>SEMI-ANNUAL</b>							
Principal				374.4	414.7	604.8	1065.
Dependent							
<b>QUARTERLY</b>							
Principal				191.1	211.6	308.7	543.9
Dependent							
<b>MONTHLY</b>							
Principal				65	72	105	185
Dependent							
<b>MAXIMUM BENEFITS</b> /illness	25000	40000	55000	30000	40000	60000	80000



Table 12: cont'd.

TYPE OF PLAN	HCD as of Mar. 7, 1989 Ward P 150/day	HMI as of Jan. 89 Private P 300/day
<b>Room Rates</b>		
<b>I. INDIVIDUAL</b>		
Annual		1100
Semi-Annual		595
Quarterly		320
Monthly		110
<b>II. FAMILY</b>		
Annual		6350
Semi-Annual		3420
Quarterly		1845
Monthly		635
<b>III. GROUP/CORPORATE min of 20 (per member)</b>		
<b>ANNUAL</b>		900
Principal		
Dependent		
<b>SEMI-ANNUAL</b>		485
Principal		
Dependent		
<b>QUARTERLY</b>		260
Principal		
Dependent		
<b>MONTHLY</b>	75	90
Principal		
Dependent		
<b>MAXIMUM BENEFITS</b>	30000	60000

servicing employees of a particular industry or overseas workers (Healthkard, Inc., St. Vincent, St. Patricks, and Waterous Medical Corp.). HMI was the first to launch an aggressive marketing strategy for individual and family plans in 1981.

Unlike in the U.S. where the predecessors of investor-based HMOs were largely not-for-profit, consumer-based organizations, investor-based HMOs in the Philippines were, from the beginning, corporations meant to operate at a profit. Philippine HMOs evolved as a response to a market brought on by a) the rapidly increasing costs of medical services, b) the inability of the wage-based population to cope with these costs, and c) the low support value of social insurance provided by Medicare. All these resulted in a natural demand for organizations which can finance and provide medical services at a cost which members can afford. Describing this targeted market, the AHMOPI President said, "we are aiming at the B C crowd, those who cannot afford the lump sum in hospitalization, but can pay a fixed amount each month, and not at the affluent people" (*Philippine Daily Inquirer*, April 15, 1988:19).

*Clientele.* Who can enroll in investor-based HMOs? What is the approximate size of the population covered and what is their client mix? Table 13 presents in capsule form the age limits of those eligible for enrollment, the approximate number of enrollees in, and the client mix for each of the 16 HMOs. Age ranges for membership in HMOs have been set at 15 days to 3 months for the youngest, to not more than 60 to 65 years for the oldest enrollees. Figures entered under the "Approximate No. of Enrollees" were those given by HMO managers who were interviewed for this research. As with most businesses, HMO enrollment figures may change over a short period of time due to such factors as lapsation of membership. For this reason, we would like to warn our reader of the tentative character of these data.

The next column indicates that HMOs' biggest clients are mostly employers. At least four of the sixteen HMOs are servicing corporate clients only. Moreover, except for Fortunecare which reported a greater percentage of individual and family clients, the HMOs cater to a predominantly corporate clientele. HMOs preference for corporate accounts is understandable given that these accounts a) ensure HMOs of a bigger population base, b) facilitate collection and other administrative processes and c) are usually on an annual basis and is less likely to be terminated earlier. Based on this table, approximate population covered by HMOs would add up to 398,500.

*Clients' Feedback on HMO Service.* As they constitute the dominant form of clients for most investor-based HMOs, four corporate clients were interviewed to provide some empirical basis for describing selected clients' accounts as to a) why they decided on securing the services of HMOs to provide for the medical needs of their employees, b) how they chose one HMO from among those operating in the market and c) what were the positive and negative feedback on HMO services given by their employees.

In view of the rather limited data base for this portion of the study, it is important for the reader to note that while the information provided below conveys some notion as to how the four companies responded to these questions, these findings could not be generalized used to refer to all HMO clients in general.

The decision to hire the services of an HMO usually starts from the recognition of the inadequacy of existing health allowances provided employees to supplement Medicare benefits. In one corporation, prior to their contract with an HMO, their health benefit package consisted of a hospital assistance loan (maximum of P2,000.00) payable in one year through monthly salary deductions. In another academic

**Table 13: HMO CLIENTELE: ELIGIBILITIES, APPROXIMATE ENROLLMENT & CLIENT MIX**

HMO	MEMBERSHIP ELIGIBILITIES	APPROX. NO. OF ENROLLMENT	CLIENT MIX
BLUE CROSS	15 days -- 65 yrs. provided they enroll before 60	5000	
FAMILY MEDCARE	a) 30 days to 55 years (terminates at 60 yrs) for individuals b) 30 days to 60 years (terminates at 65) for group	10500	almost all corporate accounts less than 5% individual less than 25% group
FORTUNECARE	3 months to below 65 yrs.	25000	40% corporate 60% ind./fam.
HEALTH CARE & DEV	3 months to below 65 yrs	4000	100% corporate
HEALTHKARD INTERNATIONAL INC.	3 months to below 60 yrs. (terminates at 65)	24000	65% corporate
HEALTH MAINTENANCE INC.	3 months to below 65 years	78000	65% corporate 15% ind./fam.
HEALTH PLAN PHIL INC.	3 months to below 65 yrs.		
INTERCARE	15 days to below 60 yrs.	5000	100% corporate just starting for fam./ind.
LIFECARE	3 months to below 65 yrs	30000	
MAXICARE	less than 65 yrs.		
MEDICARD	3 months to below 60 yrs.	18000	
PAMANA GOLDEN CARE	3 months to below 60 yrs.	90000	more than 90% corporate less than 10% ind./fam.
PHILAM CARE	15 days to below 65 yrs.	80000	60% corporate 40% ind./fam.
ST. PATRICKS	corporate employee	10000	100% corporate
ST. VINCENT	3 months to below 65 yrs.	5000	80% corporate 20% ind./fam.
WATEROUS MEDICAL CORP	corporate employee	14000	100% corporate

institution, where a credit cooperative was a source for loans for hospitalization expenses, employees felt that the maximum amount they could borrow was simply not enough to cover actual costs of hospitalization.

A much bigger company entered into a contract with three HMOs for their employees' dependents after employees requested that HMOs be considered in lieu of the existing health insurance plan for their dependents. Employees cited two reasons why they preferred HMO services over group health insurance. They contended that under the latter, they have to a) comply with hospitals' requirement that they pay a deposit when their dependents are confined and b) they have to assume full cost of the hospitalization fee, 80% of which is subsequently reimbursed after two or three months. Clearly then from the experience of these selected corporations, the rationale for seeking out HMOs over other forms of health financing schemes is their no out-of-pocket-cost-at-time-of-need feature, particularly when hospitalization is required.

How did these companies choose from among the many HMOs operating in the Metro Manila area? Companies invite HMOs to submit written proposals and depending on the size of the company, key officials of the HMO may even offer to make a personal presentation of the benefit package before employees of the corporation. The companies noted that since the benefit package tends to be similar, the presentation of the different HMOs may be crucial to the company's decision. In the case of the bigger corporation, verification of the capacity of the HMOs to serve their employees' dependents also entailed a background check on the HMOs' financial viability and their promptness in settling their hospital and doctors' bills. For this corporation, the HMOs also waived underwriting procedures which meant that there would be no rejections for any of the applicants from the company.

The experience of the four companies shows that the bigger the companies are, the more information they tend to get on the HMOs' track record and financial status before the company decides on which HMO to hire. Among the factors which companies consider are: a) the membership fees, discounts offered and the benefit package, b) special features which are not offered by other HMOs, c) manner of presentation of proposal, d) experience of their employees with the HMO (if a renewal is under negotiation), e) the financial viability of the HMO and f) the HMO's track record with hospitals.

Of the four corporate clients interviewed, three were already in their second or third year of providing health services to employees through HMOs. Their employees' satisfaction or dissatisfaction with the HMOs which had previously served them constitutes one of the major inputs into the decision-making process. There were positive and negative feedback on the quality of the service received by these employees. Among the positive ones were:

- a) Members no longer worry about hospital bills in case of confinement or emergencies.
- b) Employees were also impressed with the quality of the out-patient services they have availed of.
- c) Some HMOs try to make up for problems by sending mobile clinics with ECG apparatus to the corporations so employees can avail of their doctors' services as well as of their ECG apparatus.
- d) Some HMO doctors agree easily to patients getting their diagnostic work-ups.

Negative feedback on HMO service spring from the following concerns:

- a) Lack of appropriate explanation on how the pre-existing disease clause operates;
- b) Conflicting diagnosis of HMO staff doctors;
- c) Frequent unavailability of hospital rooms to which members are entitled, compelling them to settle for rooms at lower rates.
- d) Some HMO members felt that fee-for-service patients of some doctors get more attention. Some claimed that they were attended to only after the doctor had served regular patients.
- e) Some employees also complained of having problems getting access to HMO doctors. While the clinics are generally accessible, doctors schedules were quite tight.
- f) Two employees of a corporation were rejected by two hospitals because the HMO has not been paying its bills in both hospitals. Although the cases were settled without much delay, this has weakened the credibility of this HMO among employees of this organization.
- g) Some HMO members are uncomfortable when the doctors they consult talked badly about their HMO in their presence.

Can employees of an organization expect a better deal from HMOs because they are part of a big corporate account? Who will be responsible for the adverse effects of an HMO's accredited physicians' neglect on a patient's health or life? A formal complaint lodged by a disgruntled member against an HMO landed in the sala of a Regional Trial Court Judge after it was referred action by the Securities and Exchange Commission, the Office of the Insurance Commissioner and the Department of Health, who claimed that they had no jurisdiction over complaints against HMOs.

The case, filed by an HMO member against the HMO and four of its accredited doctors in two hospitals in Metro Manila, arose from the plaintiff's contention that the HMO doctor whom she first consulted when she needed medical attention was not only unable to diagnose her ailment correctly, the doctor actually misdiagnosed her illness, causing further deterioration of her physical condition which ultimately necessitated emergency treatment in still another hospital accredited by the HMO. Because of the unavailability of HMO doctors at the time of the emergency, she had to consult a non-accredited doctor in the hospital who asked that the patient undergo laboratory examinations. The result of the examination indicated that the patient had cancer. When her case was turned over to the HMO doctor, the plaintiff claimed that the doctor did not manifest concern for the case. Instead, this doctor advised the family of the patient that at her age and since she had cancer, the patient maybe better off if she was no longer subjected to further medical examinations or surgery. Besides, the doctor also added, this illness is no longer covered by insurance. This lack of concern and inattention in the case of the second HMO-accredited doctor and the misdiagnosis in the case of the first accredited doctor prompted the filing of a civil case against the HMO and the four doctors involved in the case. The plaintiff accused the doctors of "malicious refusal and willful negligence, incompetence, and unprofessionalism" and the HMO for limiting the patient to the professional services of such "negligent, incompetent and irresponsible" doctors and for refusing to pay the patient for the medical bills incurred for the operation performed on the patient.

The case was still pending in court when this report was written. In the meantime, the HMO member died and her heirs decided to carry on with the case. The development of this case indicates that in this situation, the corporate clients who contract the HMO to serve their employees may not take an active role in holding the HMO accountable for the quality of service of HMO accredited doctors. It becomes incumbent on the aggrieved patient to file a case in her personal capacity against the HMO. The question



is how many of the HMO members will have the resources and the capacity to file such a case in court where it is likely to take time and money.

*Providers.* Tables 14 and 15 give us a picture of the number of primary physicians, accredited doctors, hospitals and HMO clinics and medical service units mobilized by these HMOs to make health services more accessible to their clients. The number of medical professionals and the hospitals contracted by HMOs to constitute a network of facilities is an asset of any service delivery system. Even as this model is supposed to limit patients' choice only to doctors on contract with the HMOs, this does not deprive members of access to medical specialists when they need to. It must be noted that the number of doctors and hospitals accredited outside of the HMO clinic also increases the volume of administrative procedures which must be observed to link these offices to the HMO's main center. It is not uncommon to find specialists servicing more than one HMO. There are also cases where hospital coordinators attend to members of two HMOs in the same hospital.

Among tertiary hospitals in Manila (Table 15), the top seven in terms of HMO demand for their services are a) San Juan de Dios, b) Manila Doctors, c) Medical City, d) St. Luke's Medical Center, e) Polymedic General Hospital, f) The Philippine Heart Center for Asia and g) Makati Medical Center.

*Financial Arrangements With Providers* What HMO model is most commonly used by investor-based HMOs operating in the Metro Manila area? Interviews with HMO management, doctors, hospital coordinators and sales agents revealed how each of the 16 investor-based use similar modes of contracting and paying for physicians and hospital services for their members.

A combination of the staff and the individual practice models tend to be the preferred mode with discount rates for physicians and hospital fees varying within a certain range. Clinic physicians who serve at the HMO facilities are paid monthly retainers fees (or salaries) depending on the amount of time devoted to the clinic. Consultants are paid on a fee-for-service basis at pre-arranged rates or at a discount (P75.00 per outpatient or from 10-30% discount). On the average, payment is made from one to three months after the billing, though there are increasing cases of delayed payment extending over three months.

HMOs have contracts with hospitals whom they accredit as part of their network of providers. The contract stipulates its date of effectivity; the name, role, and functions of the HMO Hospital Coordinator; the mode of payment, billing procedures, and discounts and; the grounds for termination. Discounts given to HMOs by hospitals can range from 5-10% on room and board and can vary according to the volume of business brought in by the HMO. Most contracts provide that hospital bills should be settled within 15 days. Older and bigger accounts may be given an extension of another 15 days. Some HMOs have a credit line which they maintain with some hospitals. Once HMOs fail to pay within the maximum period and their bills exceed their credit line, they may be given notice of impending suspension.

Delayed payment of HMO bills is a common complaint of both doctors and hospitals. Hospitals usually study the reason for the delay on a case to case basis, giving consideration to the following factors: cause of delay, amount collectible, period of delay, the HMOs' track record for previous payments and the volume of clients referred to the hospital. It was noted that very few of the investor-based HMOs pay their bills on time. Some would pay their bill as soon as a notice of impending suspension is issued. One hospital had to file a case against an HMO whose bills were not settled after six months. The hospital had to stop servicing members of the HMO covered. A hospital administrator noted that out of the 11 HMOs serviced by the hospital, only 1 or 2 consistently pay their bills on time.

**Table 14: Service Providers**

<i>HMO</i>	<i>PRIMARY PHYSICIAN*</i>	<i>TOTAL ACCREDITED DOCTORS (MM only)</i>
BLUE CROSS	13	
FAMILY MEDCARE		
FORTUNE CARE	10 clinic physician	94
HEALTH CARE & DEV.	10	150
HEALTHKARD INT'L INC.	17	89
HEALTH MAINTENANCE INC	26	approx. 400
HEALTH PLAN PHIL. INC.	45	165
LIFECARE	32	232
INTERCARE	8	156
MAXICARE	9	135
MEDICARD	19	235
PAMANA GOLDEN CARE		
PHILAM CARE	23	262
ST. PATRICKS ST. VINCENT	30 Clinic Physician	
WATEROUS MEDICAL CORP.	12	93 Consultants in MM

**\*Primary Physicians** – is a gatekeeper, a member's designated physician who shall be in charge of his medical needs: initial consultation and check up, referral to specialist, consent to hospitalization. A primary physician is normally based in a hospital but some hold clinics outside hospitals.

**\*\*Medical Service Unit** – a group of physicians and other allied health professionals who will carry out the deliver of HMO health care program.

**Table 14: Service Providers**

<i>HMO</i>	<i>ACCREDITED HOSPITALS</i>	<i>HMO CLINICS (MM) MSUs**</i>
BLUE CROSS	8 in MM (3 outside MM)	8 MSUs
FAMILY MEDCARE	21 in MM (64 outside MM)	2 Clinics/ 21 MSUs
FORTUNE CARE	19 in MM (8 outside MM)	4 Clinics/ 19 MSUs
HEALTH CARE & DEV.	10 in MM (2 outside MM)	10 MSUs
HEALTHKARD INT'L INC.	15 in MM (1 outside MM)	14 MSUs
HEALTH MAINTENANCE INC	13 in MM (2 outside MM)	3 Clinics/ 13 MSUs
HEALTH PLAN PHIL. INC.	9 in MM (14 outside MM)	1 Clinic/ 19 MSUs
LIFECARE	16 in MM (12 outside MM)	13 MSUs
INTERCARE	10 in MM	7 MSUs
MAXICARE	9 in MM	1 Clinic/ 9 MSUs
MEDICARD	18 in MM (9 outside MM)	21 MSUs/ 8 satellite clinics
PAMANA GOLDEN CARE	16 in MM (12 outside MM)	1 Clinic/ 16 MSUs
PHILAM CARE	17 in MM (23 outside MM)	5 Clinics/ 12 MSUs
ST. PATRICKS	8 in MM	8 MSUs
ST. VINCENT	8 in MM ( 5 outside MM)	1 Clinic/ 8 MSUs
WATEROUS MEDICAL CORP.		7 Clinics

**Table 15: PARTICIPATING HOSPITALS & NUMBER OF HMOs SERVED**

<i>METRO MANILA ( 39 )</i>			
1. San Juan de Dios Hospital	13 HMOs	21. Martinez Gen Hospital	2 HMOs
2. Manila Doctors Hospital	13 HMOs	22. Mla. Central Univ Hosp	3 HMOs
3. Makati Medical Center	10 HMOs	23. UERM Medical Center	3 HMOs
4. Medical City	13 HMOs	24. Singian Hospital	2 HMOs
5. Our Lady of Lourdes Hosp.	6 HMOs	25. Sacred Heart Hospital	1 HMO
6. Perpetual Help Med. Center (LP)	8 HMOs	26. Perpetual Help Med Ctr (Samp.)	1 HMO
7. St. Lukes Medical Center	13 HMOs	27. Medical Center Manila	4 HMOs
8. Chinese General Hospital	4 HMOs	28. Metropolitan Hospital	2 HMOs
9. Polymedic General Hospital	10 HMOs	29. Pasay Paranaque Gen Hosp	1 HMO
10. Cardinal Santos Gen. Hospital	7 HMOs	30. Medical Center Paranaque	2 HMOs
11. De Los Santos Medical Center	4 HMOs	31. Waterous General Hospital	2 HMOs
12. Manila Sanitarium	5 HMOs	32. Children's Medical Center	2 HMOs
13. UST Hospital	4 HMOs	33. Quezon City Medical Center	2 HMOs
14. Mary Johnston Hospital	7 HMOs	34. St. Agnes Hospital	1 HMO
15. Our Lady Of Fatima	4 HMOs	35. St. Claire Hospital	2 HMOs
16. Capitol Medical Center	4 HMOs	36. SM Lazo Hospital	2 HMOs
17. United Doctors Medical Center	4 HMOs	37. Phil Heart Center for Asia	11 HMOs
18. Sanctissimo Rosario Gen Hosp	1 HMO	38. National Kidney Institute	6 HMOs
19. Trinity General Hosp	2 HMOs	39. Lung Center Of the Phils.	1 HMO
20. Galang Medical Center	1 HMO		
<i>PROVINCES 75</i>			
	Luzon :	46 HMOs	
	Visayas :	14 HMOs	
	Mindanao :	15 HMOs	

Source: HMO individual brochures and list of participating hospitals

**Financial Viability.** The most difficult data to secure for this research were financial statements indicating the over-all performance of the HMOs over time. Table 16 summarizes information on the capital structure, total assets, ownership of total assets and profitability of three selected HMOs in 1987. The literature on HMOs suggests that the first few years of an HMO will be difficult in terms of their operating costs. This is why, in the U.S., with the passage of the HMO law in 1973, as amended in 1976 and 1978, non-profit organizations that meet the requirements for federal qualifications may receive loans up to a maximum of \$4 million in 1978, to cover start-up costs and operating deficits (Brown, 1983: 47). It is possible that the two HMOs who suffered losses for the period covered in the table have already improved their financial status by now. It is certain though, that at one time, their financial position required that they have access to financial resources to offset losses which can affect their capacity to meet members' medical needs. During better times, i.e., when membership is high and utilization rates are within acceptable levels, HMO revenue may be allocated as follows: 20-30% for agents' commission, 40% for medical services, 20% for administrative costs and 10% for profit.

**Members' Contributions.** There are a number of factors which determine the premium rates an HMO member pays in anticipation of the health services that they may avail of. These factors are: a) hospital room rates, b) frequency of payment (i.e., annual, semi-annual, quarterly, monthly) c) number of members covered and d) additional benefits added to the package, i.e., with dental service or with executive check-up.

Table 17 shows the average premium rates for four categories of hospital room accommodations. Given the same room rate, annual, semi-annual and quarterly rates are 10%, 5% and 3% lower than the monthly rates, respectively. Again controlling for room rates, individual rates are about 30% higher than corporate rates. The lowest rate for an individual plan for a ward is 65 pesos a month.

By putting together the data from Tables 13 and 17, we have estimated the income from fees of investor-based HMOs using average annual fees rates and the estimated number of members (398,500), on the assumption that of these members, 10% will take the ward, 50% the semi-private room and 40% the private room. Table 18 presents the outcome of this hypothetical condition. For a client mix of 10-15-75% for individual, family and corporate accounts, respectively, total fees collection will result in higher income level compared to a 10-10-80% client mix. This is primarily because given the prevailing rates, a 5% increase in the family category will raise income by a higher amount than a corresponding increase in the corporate accounts. However, this information must be assessed vis-a-vis the administrative costs associated with family accounts.

**Sales Force.** HMO plans are usually paid through a general agency which is contracted by the HMO to market the product in exchange for a commission. To be accredited, general agents must have at least 5 years of experience in selling related products (life and non-life insurance). General agents usually get a 28-30% commission for plans sold. An account executive who has sold a plan gets 19% of the premium as commission; 4% goes to his agency manager and the remaining 7% goes to the general agent. If the agency manager sells the plan, he gets 23% of the premium while the remaining 7% goes to the general agent. A general agent who sells a plan gets all the 30%.

**Common HMO Benefits and Exclusions.** The package of benefits offered by most of the 16 HMOs are fairly standard except for a few who may have some add-ons i.e., the use of dialysis machine for a limited period. The four common components of the benefit package are a) preventive health care, b) in-patient services, c) out-patient services and d) emergency care.

Table 16 : Financial Profile of Selected HMOs (as of Nov. 1987)\*

	HMO X	HMO Y	HMO Z
<b>A. Capital Structure</b>			
1. Amount of Authorized Capital Stock	P 42.45 M	P 28.13 M	P 28.13 M
2. Paid-up stock	P 5.16 M	P 12.34 M	P 1.21 M
3. Percent of paid-up to Authorized Capital Stock	13%	45%	6.25%
4. Retained Earnings	P 8.03 M	P 3.78 M	P .1087 M
5. Network/ Stockholders Ownership (Retained Earnings & paid up)	P 13.77 M	P 7.97 M	P .519 M
<b>B. Total Assets</b>			
	P 36.74 M	P 12.19 M	P .694 M
<b>C. Ownership of Total Assets</b>			
Stock holder	38%	67%	55%
Creditors	62%	33%	45%
<b>D. Profitability</b>			
	shows high rates of return on investments & equity	net loss	net loss

Note.\*Peso Value data have been adjusted by a constant factor to ensure confidentiality.

**TABLE 17: AVERAGE PREMIUM RATES FOR INVESTOR-BASED HMOs**

	WARD	SEMI-PRIVATE	PRIVATE	SUITE
<i><b>INDIVIDUAL</b></i>				
Annual	830.52	990.40	1424.23	2750.10
Semi-annual	442.10	521.10	748.93	1463.40
Quarterly	225.40	267.60	385.39	749.85
Monthly	77.50	93.75	115.83	255.00
<i><b>FAMILY OF SIX</b></i>				
Annual	4219.20	5323.90	7591.33	14980.85
Semi-annual	2319.00	2857.80	3754.05	8112.14
Quarterly	1185.90	1469.60	1914.76	4079.91
Monthly	406.25	492.50	631.57	1375.50
<i><b>CORPORATE</b></i>				
Annual	632.26	751.98	1093.28	2136.35
Semi-annual	333.56	396.79	577.48	1135.15
Quarterly	170.85	204.28	286.34	582.98
Monthly	56.25	67.42	99.11	190.00

Table 18 : Estimated Fees Income of Investor-based HMOs Using Average Annual  
Fee Rates \*

TYPE OF PLAN (client mix)		W A R D	S E M I - P R I V A T E	P R I V A T E
INDIVIDUAL	(10%)	33,096,222	39,467,440	56,755,565.50
FAMILY of six	(15%)	252,202,680	318,236,122.50	453,771,750.75
CORPORATE	(75%)	188,966,707.50	224,748,022.50	376,754,060
<b>TOTAL</b>	<b>(100%)</b>	<b>474,265,609.50</b>	<b>582,451,585</b>	<b>881,281,376.25</b>

INDIVIDUAL	(10%)	33,096,222	39,467,440	56,755,565.50
FAMILY of six	(10%)	168,135,120	212,157,415	302,514,500.50
CORPORATE	(80%)	201,564,448	239,731,224	348,537,664
<b>TOTAL</b>	<b>(100%)</b>	<b>402,795,790</b>	<b>491,356,079</b>	<b>707,807,730</b>

\*

Note: Based on an approximate number of 398,000 members. Totals for each column assume all members opt for the room plan.

SOURCES: Table 7 (HMO Clientele)  
Table 11 (Average Premium Rate for HMOs)



There are common exclusions and limitations for each contract. Perhaps the least understood and therefore the one which has caused more problems is the provision on pre-existing conditions. Most contracts of HMO members stipulate that the service agreement does not cover any pre-existing disease "whether known or unknown to the member at the time of enrollment." A pre-existing disease is any illness, injury or medical condition already affecting a covered member before the effective date, if, during the period prior to being a member, 1) any professional advice or treatment was obtained by member for such illness or injury, 2) such illness or injury was by its nature and conditions evident to the member and 3) the onset and pathogenesis can be clinically determined to have started prior to the members' coverage. This illness can be covered, though, after 12 consecutive months of membership without lapsation or renewal.

A listing of common HMO benefits provided by eleven (11) HMOs and the exclusions stipulated in their service contracts are described below.

*Preventive Health Care.* Under Preventive Health Care, HMO clients may avail of the following benefits:

- 1) periodic monitoring of health problems
- 2) ongoing record of medical history
- 3) immunization services (excluding costs of vaccines)
- 4) health counselling on diets and exercises
- 5) family planning advice, and
- 6) an annual physical examination which includes:
  - a) chest x-rays
  - b) urinalysis
  - c) stool analysis
  - d) complete blood count (CBC)
  - e) ECG and
  - f) Pap smears

Four HMOs limit their ECG and pap smear tests only to adults ages 40 and above while one limits it to adults ages 41 and above. Other HMOs offer additional tests. For instance, one HMO provides for blood chemistry as well as treadmill and psychological tests. Another HMO, in its executive check-up, adds creatinine, uric acid, total cholesterol and SGPT to the list. Two other HMOs also check on Fasting Blood Sugar (FBS). Apart from these, three HMOs provide a Well Baby Care Program as an additional benefit to their Preventive Health Care Package.

*Outpatient Service.* Under this category of service, HMO clients are entitled to the following outpatient benefits:

- 1) consultations as often as required/referrals to specialists
- 2) treatments of minor injuries (excluding supplies)
- 3) treatments of minor illnesses (excluding cost of medicines)
- 4) X-rays, lab. tests and other diagnostic procedures
- 5) eye, ear, nose and throat treatments

Minor out-patient surgery is also offered by some HMOs.

*Inpatient Service.* The HMO client is also entitled to the following in-patient benefits:

- 1) room & board not to exceed daily limit of plan selected
- 2) Operating theatre/Recovery room
- 3) Services of physicians, specialists, surgeons and anaesthesiologists
- 4) Medications, anaesthesia, blood and plasma, intravenous infusions
- 5) X-rays, laboratory test and diagnostic procedures
- 6) All other services required for the proper treatment of the Plan Member

Two HMOs offer an additional benefit of 10 treatments for kidney dialysis. Another HMO provides for free ambulance services in transferring a patient from a non-accredited hospital.

For certain catastrophic conditions or illnesses, HMOs set a limit on the maximum amount of coverage per illness. Among the diseases considered as falling within "catastrophic" conditions and are therefore subject to the limit on maximum coverage are:

- 1) Neurosurgical conditions/diseases
- 2) Cirrhosis of the liver
- 3) Cardiovascular diseases/strokes
- 4) Blood Dyscracias
- 5) Collagen Diseases
- 6) Poliomyeletis
- 7) Cancer
- 8) Chronic pulmonary/Renal Disease
- 9) Meningitis
- 10) Encephalitis

Moreover, ICU confinement for diseases other than those enumerated above and for cerebrovascular accidents/illnesses are likewise subject to maximum coverage provisions.

Only two HMOs place maximum limits on malignancies, and one HMO on serious burns. The maximum allowable days for ICU confinement vary among HMOs. While one allows for only 10 days, three others provide for a maximum of 14-15 days.

*Emergency Care Service.* Three (3) HMOs entitle their members to the full benefits of their outpatient and inpatient services in cases of emergency. Other HMOs, however, list their services as follows:

- 1) medicines
- 2) oxygen
- 3) physician's services
- 4) intravenous fluids
- 5) X-rays laboratory test and other diagnostic procedures
- 6) sutures, plastic casts and dressings
- 7) blood transfusions & other blood products

In case a member is admitted to a non-accredited hospital, HMOs generally reimburse 80% of total hospital bills, inclusive of professional fees, based on the HMOs' standards. Five HMOs basically follow the same procedure except that they place a ceiling of P 5,000 for hospital payments. Finally, one HMO pays 100% of total expenses in a non-accredited hospital but subject to the amounts specified in the plan schedule.

The HMO member or his/her representative must notify the HMO by telephone or by any other means of communication, within 24 hours after the emergency has occurred. Failure of the member to give such notice may invalidate his claim unless the member can show to the satisfaction of the HMO that it was not reasonably possible to furnish such notice.

Other expenses not covered when using non-accredited hospitals are:

- a) Follow-up care
- b) Transportation to an HMO accredited hospital
- c) Supplemental charges beyond HMO limits in room rates and the accompanying rate differences for diagnostic procedures, laboratory tests and all other ancillary medical services.

*Dental Benefits.* Eleven (11) out of fourteen (14) HMOs offer dental services to their clients. Of the eleven (11), four (4) HMOs offer their dental services as part of their over-all Health Programs while seven (7) HMOs provide the services as a separate package requiring the payment of additional fees. The list of offered dental services are as follows:

- a) Annual prophylaxis
- b) Temporary fillings
- c) Simple tooth extractions
- d) Cementation of crowns and in-lays
- e) Treatment of pains, burns, cuts and blisters in the mouth
- f) consultations and oral examination
- g) gum treatment
- h) adjustment of dentures

A 25% discount is given for dental services other than those mentioned above by four HMOs.

*Maternity Benefits.* Two HMOs provide Maternity Benefits to its members. One HMO, offers a Five Thousand Pesos (P5,000) maximum limit per case of abnormal pregnancy (specifically ectopic pregnancy and uterine atony) requiring major surgical operation with the ff. exclusions:

- a) Caesarian operation and,
- b) members 35 yrs old and above

The other HMO, covers normal delivery and extends their maternal benefits to abnormal conditions arising from miscarriage, abortion and caesarian operations. This plan, however, does not cover well baby care, nursery and other related services/confinement immediately following birth up to the period of 14 days.

**Return of Payments.** Three HMOs offer a refund of total membership payments to members who have not availed of hospital confinement benefits after 10 years of continuous membership.

**Exclusions.** The more common exclusion from the benefits described above are:

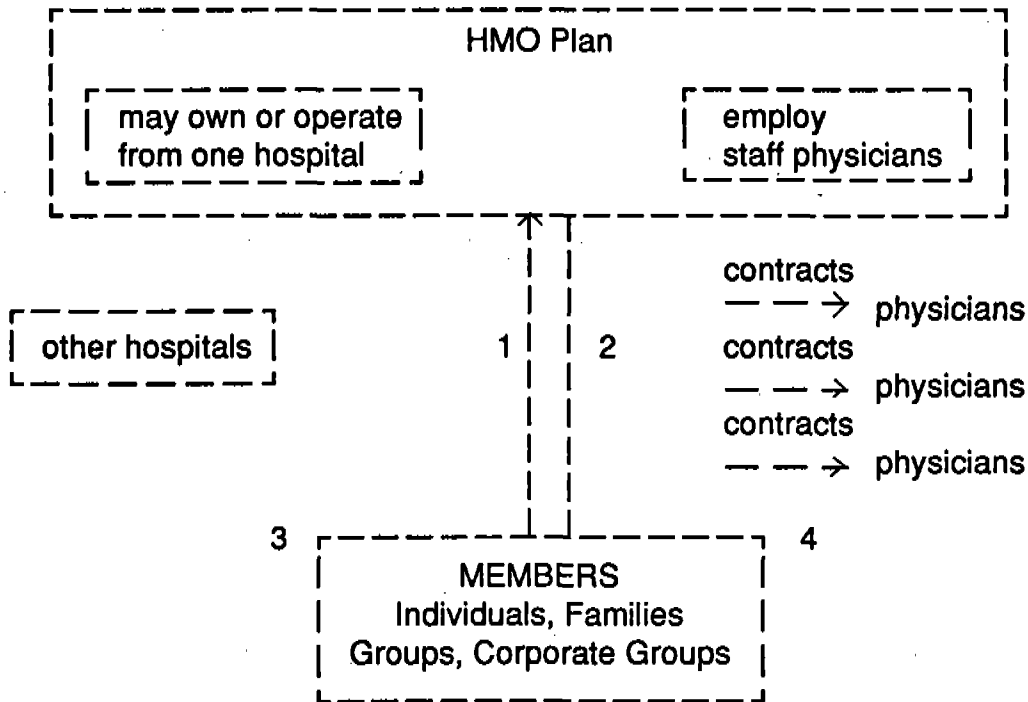
- 1) Extra charges from occupying a hospital accommodation more expensive than that specified in the schedule of benefits or supplies other than for medically necessary hospital care;
- 2) Cosmetic or oral surgery for aesthetic purposes;
- 3) Pregnancy and related condition unless specifically covered under the provisions of the optional Maternity Benefits for the plan;
- 4) Injuries or illnesses arising from war, riots and demonstrations;
- 5) Treatment of alcoholism, drug addiction or abuse or functional disorders of the mind;
- 6) Sexually transmitted diseases - gonorrhea, syphilis, herpes and AIDS;
- 7) Consequences of self injury, attempted suicide;
- 8) Care in non-affiliated hospitals or by non-affiliated physicians except under the provisions of emergency benefit;
- 9) Congenital deformities and abnormalities affecting functions of individuals.

**Philippine Investor-Based HMOs: Summary and Analysis.** To summarize, investor-based HMO companies, the more dominant form of prepaid, managed health care delivery scheme that operate in Metro Manila may be described as follows:

- 1) HMOs are essentially in their infancy stage, since these started only in the late seventies or early eighties;
- 2) They are organized primarily for profit;
- 3) They tend to have as their sponsoring companies, insurance firms or hospitals;
- 4) Their client mix indicates the predominance of corporate clients. HMOs are thus servicing those corporations' employees and/or dependents who normally belong to the lower middle or middle income class.
- 5) These HMOs are largely Manila based although some of them are starting to expand to other cities of the country.
- 6) They offer similar comprehensive package of benefits. Membership contribution rates are competitive and based on hospital room rates and services covered.
- 7) As companies which finance and deliver comprehensive health services, they operate in an unregulated environment.

Based on this characterization, two sub-categories of HMO-like companies may be established. Those which operate their own hospital, which we call the *medical facility-based type* and those which are affiliated with insurance firms the *financing organization-based HMO*.

Graphically, the prevailing practice in the Metro Manila area may be presented, thus:



- 1) Members pay a fixed amount, regardless of actual services availed of, provided within the limitations of the service contract. Financial risk for cost of medical services is transferred to the Plan.
- 2) The plan's own hospital and staff physicians, or
- 3) other private hospital contracted, which are more accessible to members, provide the medical service needed.
- 4) Physicians in fee-for-service practice agree to serve prepaid patient in their private clinics on a fee-for-service, capitation or discounted rate established between them and the Plan.

This model depicts a more loosely structured organization, particularly in so far as the plan's working relationship with contractual physicians is concerned. This can pose further problems as a crucial requirement of a successful HMO is a well established and adequate monitoring system to control quality of care and utilization of services (Group Health Association of America, Inc., 1985:3-23).

If the HMO patients only form a small fraction of the physicians' total clientele, then it is possible that the doctor's behavior in prescribing costly medical procedures may not change significantly and the corresponding cost-effectiveness goal of the HMO may not be achieved. This is a basic weakness of the Philippine model where the HMO has little or virtually no control over private practice physicians whom they also contract to serve their members. In these cases, the physicians may not be motivated to reduce cost as they do not directly share in the financial risk borne by the HMO.

## **VI. Alternatives to Investor-Based HMOs**

In this chapter, the essential features of non-market oriented HMOs and two alternative financing schemes which involve state participation will be described and analyzed. There are principally two types of non-profit HMOs in the country. The first kind is one organized by a corporate firm to service the health needs of their employees' dependents. The second type is a pilot of a community-based HMO which was initiated as part of an effort to pilot health financing schemes funded by USAID. The government programs are (1) a pilot tie-up between the Philippine Medical Care Commission and two investor-based HMOs and (2) the Makati Health Plan, a partnership between a local government unit and a private hospital.

### **A. Employer-Initiated HMO**

In February, 1988, Philippine Airlines formally started operations of its PAL Dependents Medical Plan (PDMP). While work on the establishment of PDMP started as early as November, 1987, it was implemented on a staggered basis. PAL's Metro Manila employees were covered first in February, 1988; employees outside Manila were covered in May, 1988. By June, 1988 all other administrative personnel were also covered.

Medical benefits for PAL employees are provided in their Collective Bargaining Agreement. The cost of these benefits are fully funded by PAL. Their employees have direct access to PAL's medical facilities and medical professionals. They are also serviced by hospitals retained by PAL for this purpose.

The PDMP was organized to service dependents of regular PAL employees. Each employee may enroll two dependents. This may include:

- a) When employee is single - parents (below 60 yrs. old) and brothers and sisters (at least 3 months up to 24 yrs. old); and
- b) If employee is married - spouse and children (at least 3 mos. up to 24 yrs. old)

Dependents who apply for membership normally do not have to undergo medical check up except when the applicant is suspected of suffering from a particular illness. As of December 15, 1988, PDMP has about 11,000 members.

Each employee pays P42.50 for every enrolled dependent while PAL pays the other P42.50 for a total premium of P85.00 per member. For this membership fee, members may utilize a hospital room costing not more than P250/day. Benefits enjoyed by members include a) outpatient services (excluding medicine), b) inpatient, c) emergency services and d) annual physical check-up.

The plan provides for 80% refund for in-patient services in non-accredited hospitals and a maximum limit of P50,000 for dreaded diseases. Medicare refunds could be used or credited as part of the monthly membership payment for PDMP.

Members may use PAL's Medical Clinic which has four (4) doctors (a surgeon, a pediatrician, an EENT specialist and an internist/cardiologist). The internist/cardiologist works full time with the Medical Clinic. The clinic has two full time nurses and is open 24 hours. To avail of service in the clinic and its accredited hospitals, members just need to present their PDMP membership card.

The PDMP manager noted that thus far, it has not been confronted with major operational problems. She attributes this to the fact that they have been in operation for less than a year. She explains that members of the plan are able to avail of medical services in hospitals accredited by the plan.

To summarize, PAL's Dependents Medical Plan functions as an employer-initiated HMO. It may be distinguished from investor-based HMO in that:

- 1) It operates as a non-profit organization.
- 2) It serves only dependents of PAL's regular employees.
- 3) Half of the membership fee is paid by employees while the other half is paid by PAL as employer.
- 4) Membership fee rates are higher than consumer-based HMOs but slightly lower than investor-based HMOs.
- 5) Benefit package is basically similar to those offered by investor-based HMOs.
- 6) At the time of the research, it has been in operation for less than a year.

#### B. *Consumer-Based HMOs*

In 1983, USAID introduced its Primary Health Care Financing Project. This triggered considerable interest in, and led to the initiation of pioneering studies on community and primary health care financing projects in the Philippines. One of the components of this project is the design and piloting of an innovative health care financing scheme which may be replicated if found workable. Among the ideas explored was Intercare's proposal to pilot test the HMO approach as a health care financing scheme for employees of private companies without company funded benefits and a community in Pandacan serviced by a mix of private fee-for-service providers and government funded health care (PCHRD, 1985: 93-110).

After reconsidering the choice of the initial situs of the research, Intercare Research Foundation, Inc., with the support of the Philippine Council for Health Research and Development (PCHRD) and the USAID, initiated as a pilot project the organization of two consumer or community-based HMOs in the communities of barangay San Antonio, Biñan, Laguna and in the UP Diliman Campus.

Through the project, Intercare undertakes a feasibility study to assess the viability of establishing an HMO in a specific community. Where HMO development is considered feasible given the community's economic character and health needs as established through actuarial projections, then Intercare provides technical assistance and training support to the community which will collectively own and manage the community-based HMO. After giving the community and its HMO managers technical guidance in various stages of HMO organizing and development, Intercare will eventually phase out and leave the community to manage its consumer-based, non profit HMOs.

The San Antonio and UP HMO's membership fees are considerably lower than that of an investor-based HMO. In the case of the UP HMO, the lower membership fees may also be due to the fact that most of its accredited hospitals are government health facilities in the area. Table 19 shows the average monthly fees for these two consumer-based HMOs. This type of HMOs do not have corporate clients and its membership is limited to residents of a defined area.

**Table 19 : Average Monthly Fees Rates for Consumer-Based HMOs  
(San Antonio, Biñan and UP-Diliman)**

	<i>Ward P80/day</i>	<i>Semi-Private P150/day</i>	<i>Private P200-250/day</i>
Individual	P33.27	P44.22	P55.19
Family of Six	288.21	295.27	364.14

Like the investor-based HMOs, these two HMOs are also registered with the SEC, with the core group of leaders and coordinators also serving as incorporators. They likewise offer basically the same set of benefits, i.e. preventive care, out-patient, in patient and emergency care. Exclusions and limitations are similar to those of investor-based HMOs where pre-existing conditions are not covered until after one year of membership.

This exploratory effort is aimed at stimulating more organized action leading to the formation of a consumer-based HMO. It is a collaborative program which brings together the private sector, through Intercare, the government, represented by the Philippine Council for Health Research and Development (PCHRD) which awards and monitors the research grant, and the USAID, which provided the funds for the whole project.

These consumer-based HMOs share common characteristics:

- 1) They evolved as an outcome of an attempt to organize, on a pilot basis, consumer-based HMOs.
- 2) They function as non-profit organizations.
- 3) Their clientele is limited to residents of a defined community.
- 4) They charge lower membership fees compared to investor owned and employer-initiated HMOs.
- 5) While their benefit package is essentially similar to those offered by the two other types of HMOs, one consumer-based HMO utilizes only public hospitals in its network of providers.
- 6) They have been in operation for less than a year.

The San Antonio HMO started its operation on September 9, 1988 while the UP HMO started only in January, 1989. As of June 1990, San Antonio HMOs had a total membership of 400 while the UP-HMO has 429 enrollees. In terms of their financial status, San Antonio has consistently incurred deficits, with its accumulated deficit as of June 1990 adding up to P 47,427.24. UP-HMO incurred deficits for the year 1989 but has registered a net income of P9,907.30 for the first six months of 1990 (Hewspeccs Inc. and Intercare Research Foundation, 1990).

Hewspeccs' final report on the pilot effort draws certain lessons from its experience in establishing and operating consumer-based HMOs. Among these are:

- 1) HMOs are not for people who are very poor and have no regular source of income.
- 2) To set up community based HMOs, there must be credible and reliable community leaders who understand and appreciate its concept.



3) The choice of the Medical officer to staff the primary service unit is critical for the success of a community-based HMO.

4) Being an innovation in the community, HMO will not be able to attract members immediately.

5) All HMO members must be fully informed of HMO procedures and processes.

6) Accredited facilities and providers should also be fully informed of HMO procedures and processes.

7) HMO management requires coordinated and synchronized action from different individuals performing specialized tasks (Hewspeck & Intercare, 1990: 25-26).

### C. *The PMCC-HMO Tie Up Project*

As of the time of this research, there is no one explicit policy statement defining the relationship between the Philippine government and the types of HMOs described above, particularly the investor-based HMOs. This condition has not been a deterrent to government's taking the initiative to explore possible government-private sector collaboration which can lead to greater cost-effectiveness and equity in the financing and provision of health services. The succeeding portions of the study, will discuss two ongoing health financing projects which are undertaken in Metro Manila, one by a national government agency and another by the municipal government of Makati. These projects are illustrative of schemes which government can consider in its search for alternative financing schemes. The national government project involves a social insurance-HMO partnership. The local government effort shows how a municipal government can contract a private hospital to provide comprehensive health services to low income families in the municipality.

In 1987, the Philippine Medical Care Commission, the policy making and regulatory body which formulates policies and monitor abuses in the implementation of the Medicare program, conceptualized a pilot project where it sought to utilize private health service providers in meeting the health needs of its Medicare members. This is part of its continuous effort at increasing medical benefits for its employed population without increasing premium payments. The Medicare-Private Health Insurance Tie Up Project, as it was popularly referred to, is a novel scheme through which Medicare pays on a per capita basis, the private health care providers (HMOs or Health Insurance companies) who will arrange for and/or render the services directly to Medicare beneficiaries. This is done on the condition that the service provider assures the Medicare beneficiary of a health benefit package which is superior to what the beneficiary currently enjoys under the Medicare plan, at no extra cost.

*Features of the Project.* The concept was first discussed with private health insurance companies and HMOs in July, 1987. By September, 1987, four HMOs had submitted proposals. Medicare looked into the financial viability of HMOs which signified interest in joining this pilot project. On June 30, 1988, PMCC signed a memo of agreement with Healthkard, Int'l. the first HMO to participate in the pilot tie-up project. July and August were devoted to marketing, with the program commencing its operations by September, 1988. This experiment, which is being piloted in the Metro Manila area, has the following features:

1) Medicare members from either the public or private sectors will be allowed to participate on a voluntary basis. Private insurance companies will do the marketing to entice Medicare members to enroll.

2) Private insurance companies will do the servicing of enrolled members. Medicare will monitor service performance and render assistance as may be requested by members.

- 3) SSS and GSIS will continue to perform premium collection function and will correspondingly be compensated for such functions.
- 4) Medicare premium collection, net of administrative charges of SSS and GSIS, will be the maximum capitation payment to private insurance company.
- 5) Medicare will issue terms of references on which interested insurance companies will base their proposal. The best evaluated proposal will be awarded the right to do servicing.
- 6) Experiment will be conducted over a period as may be deemed appropriate.

The rules and regulations of the "Medicare Experimental Alternative System", as the project is also known, detail the benefit package, define a bed to covered population ratio, set a desired level of financial resources which HMOs must maintain, and require the HMO's posting a performance bond. They likewise establish the commission's power to supervise the implementation of the experiment.

*Participants.* Two HMOs are now participants of this program, Healthkard Int'l. and Pamana, Inc. Table 20 compares the benefits enjoyed by beneficiaries under the current Medicare program with the benefits offered by the two participating HMOs, with no additional premium payments.

One major advantage of the tie-up project is that it provides out-patient benefits which are not available under the Medicare program. Moreover, while SSS beneficiaries have slightly higher limits for room and board, SSS and GSIS beneficiaries are entitled to the same level of benefits under the tie-up project. Effective August 1, 1989, however, President Corazon Aquino, through Executive Order No. 365, increased and equalized Medicare benefits for both GSIS and SSS medicare beneficiaries.

Table 21 presents and analyzes the additional benefits offered by Healthkard and Pamana over the current SSS/GSIS benefit by looking at percentage increases for maximum benefits enjoyed under the pilot project. It is interesting to note that Healthkard is able to offer higher limits on room and board for primary hospitals and for operating room fees, while Pamana offers a bigger maximum limit for medical and dental practitioners' fees. This capacity to offer higher benefits may be due to the fact that Healthkard is hospital-based and therefore has more control over hospital rates while Pamana may have more control over doctors' fees.

*Project Evaluation.* Initial PMCC status report on the project for the period September 1, 1988 to May 31, 1989 showed that some 12,567 Medicare members coming from thirty two government agencies and 125 private companies and their 37,701 dependents are now HMO members through this joint venture between the PMCC and selected HMOs. Of this number, fourteen members availed of in-patient services while 320 sought and were extended out-patient services. Average value paid for in-patient claim for this period was ₱ 411.10.

For this same period, the Social Security System and the Government Service Insurance System remitted to their HMO partners a total of ₱ 609,532.03. Some 98% of this amount, (₱ 596,757.12) covers membership fees of 8,392 SSS members, while the remaining 2% (₱ 12,774.91) represents membership fees for 396 GSIS members.

PMCC's goal of increasing benefits to members at no extra cost is to be applauded. This goal should be achieved at reasonable financial risk level to the HMOs. The PMCC, who is a consumer in this case, is also a prospective regulator. As consumer it is interested in getting the best deal for Medicare members.

Table 20. SCHEDULE OF BENEFITS OF PMCC TIE-UP WITH HEALTHKARD INTERNATIONAL AND PAMANA INC.

BENEFITS	EXISTING MEDICARE PROGRAM	HEALTHKARD INTERNATIONAL, INC.	PAMANA, INC.
A. Outpatient Services	<ul style="list-style-type: none"> <li>- Minor surgery</li> </ul>	<ul style="list-style-type: none"> <li>- Free unlimited number of general medical consultations</li> <li>- Free unlimited number of optometric examinations/consultations</li> <li>- Minor surgery</li> </ul>	<ul style="list-style-type: none"> <li>- Free of charge on general medical consultations for an unlimited number of visits and treatment for minor illness and/or injuries not necessitating hospitalization</li> <li>- Optometric service for acuity test or refraction only</li> <li>- Minor surgery</li> </ul>
		<ul style="list-style-type: none"> <li>- Medical expense and professional fee benefits for Chemotherapy, Radiotherapy or Hemodialysis on outpatient basis subject to rules under catastrophic cases.</li> </ul>	
		<ul style="list-style-type: none"> <li>- After initial availment of this benefit, patient shall be automatically transferred to the regular Medicare Program.</li> </ul>	
B. Other Services		<ul style="list-style-type: none"> <li>- Free unlimited dental education and consultations</li> <li>- Free unlimited number of professional services in administering immunizations (materials and vaccines not included)</li> <li>- Free regular health education and information services</li> <li>- Unlimited ambulance service within Metro Manila</li> <li>- Annual check-up with co-payments for the following packages:               <ul style="list-style-type: none"> <li>1) CBC, Urinalysis, Fecalalysis, Physical Exam., Flourography 74.00</li> <li>2) CBC, Urinalysis, Fecalalysis, Physical Exam., Chest X-ray (10 x 12) 100.00</li> <li>3) CBC, Urinalysis, Fecalalysis, Physical Exam., Chest X-ray (11 x 14) 115.00</li> </ul> </li> <li>- Unlimited domicillary care</li> </ul>	<ul style="list-style-type: none"> <li>- Free of charge dental services such as: simple extraction, treatment of burns, lissions and gum infections, temporary fillings, recementation of jackets, crowns, inlays and outlays and dental consultations. Other dental services are offered at discounted rates.</li> </ul>
		Co-Payment ----- P 300.00	

BENEFITS	EXISTING MEDICARE PROGRAM						HEALTHKARD INTERNATIONAL, INC.						PANAMA, INC.	
	SSS Beneficiaries		GSIS Beneficiaries		Hospital Category		Hospital Category		Hospital Category		Hospital Category		Hospital Category	
	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary
C. INPATIENT SERVICES:														
1. Room & Board/day	P 30	P 35	P 45	P 20	P 24	P 33	P 40	P 45	P 45	P 35	P 45	P 55	P 45	P 55
		(maximum 45 days - members maximum 45 days - dependents)					(maximum 50 days - members maximum 50 days - dependents)			(45 days of confinement for both member & dependents)				
2. Med. Expense Benefits per single period of confinement														
a. For Ordinary Cases														
1. Drugs & Medicines	175	200	300	150	175	250	190	215	310	200	300	400	300	400
2. X-ray/Lab./Others	75	150	350	50	75	100	85	170	360	100	200	450	200	450
b. For Intensive Care Cases														
1. Drugs & Medicines	375	400	500	250	300	350	415	415	520	400	500	600	500	600
2. X-ray/Lab./Others	125	200	500	100	125	250	140	210	520	150	300	675	300	675
c. Catastrophic Cases														
1. Drugs & Medicines	-	800	1,000	-	400	450	-	300	1,050	-	950	1,200	950	1,200
2. X-ray/Lab./Others	-	400	1,000	-	150	300	-	600	1,100	-	600	1,200	600	1,200
3. Medical/Dental Practice Fee shall be P20 per day not to exceed:														
a. For Ordinary Cases (per single period of confinement)	200	200	200	200	200	200	240	240	240	500	500	500	500	500
b. For Intensive Care/Catastrophic Cases (per single period of confinement)	300	300	300	300	300	300	350	350	350	750	750	750	750	750
4. Surgeon's Fee														
		shall be in accordance with the Relative Value Scheme prescribed by the Commission not to exceed P650						Based on RUV scheme, maximum of P700					Based on RUV scheme, shall be in accordance with the Relative Value Scheme prescribed by the Commission (P60/RUV) plus 15% thereof but not to exceed P 800	

BENEFITS	EXISTING MEDICARE PROGRAM			HEALTHCARE INTERNATIONAL, INC.:			PANAMA, INC.		
	SSS Beneficiaries Hospital Category Primary: Secondary: Tertiary:	GSIS Beneficiaries Hospital Category Primary: Secondary: Tertiary:	not to exceed 30% of the allowable surgeon's fee	Primary: Secondary: Tertiary:	Primary: Secondary: Tertiary:	not to exceed 30% of surgeon's fee	Primary: Secondary: Tertiary:	Primary: Secondary: Tertiary:	not to exceed 1/3 of the allowable surgeon's fee
5. Anesthesiologist's Fee									
6. Operating Room Fee for Surgical Procedure under the following brackets of Relative Unit Value (RUV):									
a. Procedure with RUV 5.0 and below	30	35	65	30	35	65	75	75	35
b. Procedure with RUV 5.1 to 10.0	-	120	165	-	120	165	175	175	-
c. Procedure with RUV 10.1 and below	-	170	225	-	170	225	245	245	-
7. Fees for Surgical Family Planning Procedures (for the member & spouse only): Vasectomy Tuba Ligation	200 300	200 300	200 300	200 300	200 300	200 300	325 350	325 350	250 350
- For non-emergency care of non-affiliated physician but Medicare accredited physician in an affiliated hospital, a member shall be entitled to		100% of the existing/regular Medicare benefits on professional fee			80% of the regular Medicare benefits on professional fee				80% of the regular Medicare benefits on professional fee

**Table 21: Percentage Increase in GSIS and SSS Benefits  
As a Result of HMO Tie-up**

<i>Inpatient Service</i>	<i>HEALTHCARD</i>					
	SSS			GSIS		
	Primary	Second	Tertiary	Primary	Second	Tertiary
1. Room & Board	33.3	28.6	–	100	87.5	36.4
2. Medical Expense benefits per single period of confinement						
a. for ordinary cases	10	10	3.1	37.5	54	91.4
b. for ICU cases	9	4.2	4	55.7	47.1	73.3
c. catastrophic cases	–	25	7.5	–	172.7	186.7
3. Medical/Dental Prac. Fee shall be P 20/day not to exceed						
a. for ordinary cases	20	20	20	20	20	20
b. for intensive care	16.6	16.6	16.6	16.6	16.6	16.6
4. Operating Room Fee						
a. procedure w/ RUV 5.0 and below	150	114.3	15.4	150	114.3	15.4
b. RUV 5.1 – 10	175	45.8	6.1	175	45.8	6.1
c. RUV 10 and above	245	44.1	8.8	245	44.1	8.8
5. Surgeons Fee (based on max. limit of P650)	based on RUV scheme not to exceed P700					
	7.7	7.7	7.7	7.7	7.7	7.7

SOURCE: Phil. Medical Care Commission.

Table 21: continuation

<i>Inpatient Service</i>	<i>PAMANA</i>					
	SSS			GSIS		
	Primary	Second	Tertiary	Primary	Second	Tertiary
<b>1. Room &amp; Board</b>	16.7	28.6	-	75	87.5	66.7
<b>2. Medical Expense benefits per single period of confinement</b>						
a. for ordinary cases	20	42.2	30.8	50	100	142.8
b. for ICU cases	10	33.3	27.5	57.1	88.2	112.5
c. catastrophic cases	-	29.2	20	-	181.8	220
<b>3. Medical/Dental Prac. Fee shall be P 20/day not to exceed</b>						
a. for ordinary cases	150	150	150	150	150	150
b. for intensive care	150	150	150	150	150	150
<b>4. Operating Room Fee</b>						
a. procedure w/ RUV 5.0 and below	16.7	14.3	7.7	16.7	14.3	7.7
b. RUV 5.1 – 10	-	20.8	21.2	-	20.8	21.2
c. RUV 10 and above	-	17.6	33.3	-	17.6	33.3
<b>5. Surgeons Fee (based on max. limit of P650)</b>	based on RUV scheme plus 15% thereof not to exceed P800					
	23	23	23	23	23	23

As prospective regulator, it must guard against the possibility that HMOs offer services at very low membership fees that they have to cut corners and sacrifice the quality of their service. This could put the credibility of the HMO concerned at stake. PMCC's responsibility in this project is two-fold; 1) It promotes the interest of Medicare members who will be able to enjoy more benefits at no extra cost. 2) It also ensures that HMOs will not be tempted to participate in the project at precariously high financial risk which may have implications for the quality of the service they render.

By December 1990, a PMCC-HMO Tie up project evaluation report was completed. It concluded that the tie up project is financially viable and attractive for the HMOs. The HMOs were estimated to have realized a net income before tax of more than P4.4 million inclusive of liabilities incurred but not recorded. Disaggregated per member, this translates to P=7.50 per member per month for Healthkard and P10.17 per member per month for Pamana.

While the project meets PMCC's objectives of providing additional benefits for the same premium, several weak points of the tie-up program are observed. These are: lack of information among members, low first year utilization, poor patient and provider education, and extensive administrative difficulties.

What is more significant for policy makers to note is the tendency for HMOs to get the healthier members of the working group who are based in Metro Manila. This phenomenon may have serious implications for achieving equity among Medicare members. Thus, SSS and GSIS noted that under the tie up project:

1) There is adverse risk selection of the HMOs so that the principle of cross-subsidy within the regular medicare program is lost. HMOs tend to attract younger and healthier members to enroll in the tie up project. This is because they tend to get big companies in Metro Manila whose employees may belong to the middle class and are relatively healthier. Over time, this pattern would leave the SSS and GSIS with most of the expensive medical risks.

2) Catastrophic cases are reverted to the regular Medicare program after initial serving by the HMOs. The concern here is that Medicare will actually spend more than the premium amount by providing service to the sickest members of the tie-up project.

3) HMOs, because of other administrative and marketing costs, plus a profit margin, may really apportion a smaller share of the premium to payments for medical benefits other than Medicare (Philippine Medicare Care Commission, 1990: 81). This will mean less benefits for members.

#### *D. The Makati Health Plan: A Four-Way Partnership in Funding Health Care For Low Income Groups At A Local Government Level*

The Makati Health Plan, (MHP) is the successor of the Makati Indigent Plan (MIP) which was first instituted by Nemesio Yabut, Mayor of Makati in 1972. The MHP was the outcome of Mayor Binay's decision to review the MIP for the purpose of expanding and improving the program. The program's main goal is to make quality medical care accessible to low income Makati residents and to all Makati municipal government employees. To accomplish this goal, the municipal government of Makati, the Makati Medical Center, the Makati Medical Center medical staff and the members of the plan agreed to pool their fund, services and facilities together to forge a four cornered health financing collaborative effort.



The basic philosophy, structure and funding arrangements for this program, as implemented from May 1986 to April, 1988, will be described below. It is an alternative scheme which shows how local government units or other state agencies can work together in their attempt to evolve public-private collaboration in financing health services for lower income groups.

**Membership.** Since May, 1986, membership in the MHP is open to the following:

- 1) all Makati families whose monthly income is P5,000.00 or less;
- 2) all barangay officials of the municipality;
- 3) all municipal government employees;
- 4) all municipal policemen;
- 5) all municipal firemen; and
- 6) all Makati teachers

Explicitly excluded are beneficiaries' dependents who reside outside Makati and domestic helpers and/or household employees of Makati residents.

Members of the MHP are categorized into three income brackets which form the basis for determining the amount of token fees they are expected to contribute as their share of the medical costs incurred for providing specific types of services. The three income categories are as follows:

**Table 22 : Token Fee Per Income Category and Type of Service Per Confinement**

	<i>INCOME CATEGORY</i>	<i>TYPE OF SERVICE</i>	<i>TOKEN FEE</i>
A.	MHP Class I (Less than P2,000 monthly income)	Medical	P200.00
		Obstetrics	100.00
		Surgery	400.00
B.	MHP Class II (P2,000-P3,000 monthly income)	Medical	P300.00
		Obstetrics	150.00
		Surgery	600.00
C.	MHP Class III (P3,001-P5,000 monthly income)	Medical	P400.00
		Obstetrics	200.00
		Surgery	800.00

Source: *Bulletin of Makati Health Program*, undated: 10.

Over an eight month period covering May-December, 1986, token fees collected from patients' contribution added up to P839,606.66. A bigger amount, P 1,663,633.90, was collected from May, 1987 to April, 1988, covering a longer period.

**Screening of Member-Beneficiaries.** Every eligible beneficiary must file an application for membership with the MHP office located at the Makati Municipal Hall. Applicants may be required to submit any, all or a combination of the following documents depending on the basis of their eligibility:

- 1) resident certificate
- 2) voter's affidavit or voter's ID
- 3) certificate of residency from Barangay Captain specifying and/or verifying, length of residency
- 4) certificate of employment
- 5) certificate of separation from service or unemployment
- 6) income tax return (ITR)
- 7) affidavit of economic status for the self-employed or persons with no definite employment
- 8) marriage contract/birth certificate for legal spouse and children; affidavit in lieu of foregoing document to establish the proper dependents
- 9) Medicare form properly filled up and signed, for those who are Medicare members/dependents
- 10) Identification cards for municipal employees and police or fire station personnel
- 11) any other pertinent papers deem necessary by the social workers evaluating the application

An evaluation committee has been constituted to assess application for MHP membership. The evaluation involves examination of the submitted documents and further verification through home visits undertaken by MHP social workers. As soon as the application is approved, a permanent MHP card is issued, replacing a temporary one-month MHP ID card. Only eligible beneficiaries who are 21 years old or older are provided MHP ID cards and only one card is issued for married couples and their dependents.

As of June, 1988, there are 49,164 MHP cardholders, broken down as follows:

		<i>Number</i>	<i>Percentage</i>
Residents	-	27,779	56.50
Employees	-	8,190	16.66
Senior Citizen	-	13,195	26.84
<b>TOTAL</b>		<b>49,164</b>	<b>100.00</b>

**The Financial Share of the Makati Municipal Government.** Through a contract with the Makati Medical Center (MMC), which is to make available a package of medical service to MHP beneficiaries, the Makati municipal government is committed to pay P 9.5 million from May 1986 to April, 1987. Apart from this, the municipal government had to pay the arrears incurred by the MIP, MHP's predecessor, which amounted to P 7.5 million. A renewed contract for May, 1987 to April, 1988 again provided for a contract price of P 9.5 million. All in all, the Makati Municipal government had spent a total of P 26.5 million from May, 1986 to April, 1988, including back payment for arrears. The municipal government remits 1/12 of the agreed annual contract price to MMC monthly.

***The Makati Medical Center's Share: Health Facilities and Services.*** In exchange for the financial subsidy of the Makati municipal government and the token fees collected from patients, the Makati Medical Center agreed to make its facilities and services available to MHP beneficiaries. More specifically, it is responsible for:

- 1) Ensuring that 75 ward accommodations (adult, pediatric, nursery/bassinet) are available to MHP beneficiaries who will need in-patient care;
- 2) Maintaining an out-patient clinic for MHP beneficiaries who will require out patient consultation and ambulatory care;
- 3) Making available the Makati Medical Center emergency room to the MHP for emergency consultation and /or treatment;
- 4) Organizing and maintaining a Social Service Section which will screen or verify eligibility for membership to the MHP
- 5) Providing adequate personnel to service all facilities and office within the Makati Medical Center with functions and/or activities related to the MHP, and
- 6) Constituting within the Makati Medical Center, a Makati Health Program Committee which shall formulate and enforce rules, regulations and standard operating procedures that shall govern the conduct of the Makati Health Program.

***The MMC Medical Staff's Role: Professional Service at No Extra Cost.*** MHP beneficiaries avail of professional services provided by a roster of participating volunteer members of the Makati Medical Center consultant staff, supported by the MMC house and nursing staff, at no extra cost to the program. The hospital's doctors and nurses extend valuable contribution to the program through the expert advice and services they extend MHP beneficiaries.

***Medical Cases Covered by the Program.*** The MHP covers all non-infectious cases except psychiatric and kidney in-patients, primarily because there are government institutions with adequate, if not better, facilities (National Mental Hospital and Kidney Center) for the treatment of these cases. Infectious diseases are not covered by the program as they entail confinement in isolation room and the program provides only ward accommodations. While infectious patients are usually transferred to the Jose Reyes Hospital or to any government hospital of the patients' choice, those who become infectious due to complication of their initially non-infectious diseases, stay on and are provided continuous treatment at the MMC. While all obstetric cases were covered by the program when it first started, the MMC advised Mayor Binay to build lying-in facilities for low-risk OB cases to allow MMC to handle more adequately high risk pregnancies.

***Program Funding Sources: Who Contributes What?*** Table 23 summarizes the performance of the MHP in terms of the number of patients serviced, total cost for all services rendered (based on MMC charges), average cost for in-patient and out-patient services, and the percentage share of the total cost borne by the contributors to the program.

The period covered by the three columns of this table, reflect three distinct phases of the program. Despite variations in these periods, certain trends are discernible. The total cost of providing service for this program has consistently gone up notwithstanding the increase/decrease pattern in number of patients serviced. Comparison between the 1986 and the 1988 columns indicates that total cost has gone up by more than 100%. The municipal government's cash subsidy for the services has remained constant for the

Table 23

**Patients Served, Total Costs, Funding Sources, and Percentage Share by Funding Source, Makati Indigent Program (MIP) and Makati Health Plan (MHP) (Jan., 1986 – Apr., 1988)**

	1 MIP Jan. 1986 – Apr. 1986	2 MHP May–Dec. 1986	3 MHP May 1987 – Apr. 1988
<b>A. Total No. Of Patients Served</b>	4,754	26,595	22,833
In–Patient	1,685	4,065	5,659
Out–Patient	3,069	22,530	17,174
<b>B. Total Cost Of Health Care</b>	P 4,781,095.00	P 14,592,013.00	P 35,900,842.08
In–Patient Care Cost	P 4,257,561.00	P 14,592,013.00	P 30,720,560.60
Out–Patient Care Cost	P 523,534.00	P 1,276,381.00	P 5,180,281.48
Average Cost/In–Patient	P 2,526.74	P 3,589.67	P 5,428.62
Average Cost/Out–Patient	P 170.59	P 184.96	P 301.64
<b>C. Funding Sources</b>			
		4	4
Makati Municipal Government	P 2,375,000.00	P 7,125,000.00	P 9,500,000.00
Patients' Contribution (Token Fees)		P 839,606.66	P 1,663,633.90
Makati Medical Center/Medical Staff		P 7,903,788.33	P 24,737,209.10
<b>D. Percentage Share of Total Cost By Funding Source</b>			
Makati Municipal Government		44.9 %	26.46 %
Patients' Token Fees		5.29 %	4.63 %
Makati Medical Center/ Medical Staff		49.8 %	68.9 %

**SOURCES:**

- 1  
Intercare, Health Care Financing in the Philippines: A Country Study  
(Manila: May 15, 1987), p.181
- 2  
Bulletin on Makati Health Program (Undated), pp.12–13.
- 3  
Accounting Dept, Makati Medical Center
- 4  
P 9,500,000.00 Annual Contract price divided on a monthly basis.

period covered. Moreover, absolute increase in patient's token fees did not account for an increase in its relative share of total cost. This has resulted in Makati Medical Center and its medical staff's supporting as much as 69% of the programs' total cost for 1987-1988.

Considering the relative financial capacities of the four contributors to this program, the bigger share borne by the Makati Medical Center and its staff results in a redistribution effect. The MMC is assured a regular income from the cash subsidy of the municipal government even as it also subsidizes cost of the service through the use of its facilities and medical staff. Clearly, this funding scheme promotes equity even as it also provides indigent clients' access to quality medical care.

Under this model of government-private sector collaboration, a local government unit may contract for medical health services for a particular group of low-income beneficiaries, with the beneficiary participating in an affordable cost-sharing scheme and the private medical centers and its staff making available their facilities and professional expertise for a set fee. This arrangement is one scheme which financially-able local government units or even the national government can explore. The contract price can be negotiated depending on the hospital accommodations needed. The local government unit then need not worry about hospital maintenance costs while the private hospital is assured of regular income and can minimize problems attributed to unpaid hospital bills resulting from client's inability to pay for prohibitive costs of undergoing surgery or extended confinements. A new development that may have to be closely monitored in this connection is Makati Municipality's construction of its own hospital. How this will affect the program would be an interesting topic for future research.

## **VII. Summary and Conclusions, Areas for Policy Intervention and Research Agenda**

This chapter summarizes the findings of the study and points to areas of possible policy intervention suggested by the findings. It also proposes a research agenda which can lead to a more definitive evaluation of HMO's role in health care financing in the Philippines.

### **A. Major Findings**

The emergence of HMOs in the Philippines must be situated in the context of the country's economic and health conditions. While pneumonias and tuberculosis have consistently remained among the top killers, diseases of the heart and the cardio-vascular system have emerged as the leading cause of death in the country. These patterns of mortality and morbidity are attributed to continuing economic deprivation compounded by adverse effects of stress and environmental pollution associated with modernization.

For their health needs, Filipinos avail themselves of health services provided mainly through two parallel sub-systems: the private and public providers. The public health sub-system consists mainly of a state funded and managed public health system which charges minimal, if any, fees for its services. The private sector consists of a network of providers and health facilities which function largely along market determined costs. Another feature of this system is the inequitable geographic distribution of health facilities and medical professionals. Both tend to converge in urban centers where there is greater capacity to pay for the increasing cost of medical care. As household incomes increase, they tend to use private

health facilities more. A fourth feature of this health care system is its reliance on the fee-for-service mode of payment for private sector-provided services, even as various sources of funds for health services are identified, i.e., individual and corporate taxes, grants and loans, insurance premiums, wages, contribution and donations.

The Philippine economy reflected a consistently downward trend in GNP in the early eighties, to be reversed by an upswing after 1986 and the following two years, and then to decelerate again after 1988. Thus its economic outlook has been all but rosy.

This economic environment had its effects on the health sector. The search for alternative financing schemes through which people may protect themselves from prohibitive hospitalization costs was prompted by factors such as: 1) the decreasing buying power of the peso, 2) the decreasing percentage of family expenditures devoted to health services, 3) the phenomenal increase in the price of medical services and medicinal and pharmaceutical supplies and 4) the decrease in the support value of Medicare for hospitalization bills.

People dreaded the thought of being sick as this was associated with a financial crisis also. In this economic environment, HMOs evolved as one way through which members may pool their risks of getting sick under one financial mechanism which also assures their access to a package of health services.

The variety of HMOs which emerged in the Greater Manila area and adjoining provinces suggests that market and state forces are actively searching for appropriate ways of responding to the health needs of its population in such a manner that it promotes equity and efficiency. Figure 5 depicts the structural factors and the conditions of the health sector, described above which give rise to different interventions in this system which led to the adoption of market-oriented and state-initiated schemes. Four major sources of intervention are identified in this figure: the state, investors, employers and international assistance organizations. Their interest is generated by different concerns and has led them to develop different health financing schemes. Of the five schemes analyzed in this research and depicted in this figure, those with state intervention had succeeded in providing members access to services either at no additional cost to them (as in the PMCC-HMO tie up project) or at a much lesser cost than those which relied on market or other factors. This observation is significant in view of the fact that a greater number of Filipinos may be considered not only as medically indigent but has incomes hardly adequate for their basic needs.

As shown in the discussion of the nature and operations of investor-based HMOS, only wage earners who have some surplus may be able to afford the membership fee which must be paid regularly. Even the relatively lower membership fees charged by community-based HMOs would still be too high or financially-inaccessible to the members of the group. It is crucial therefore to explore other health financing schemes which will enable lower income groups to pool their risks and generate resources which they can tap for future health and medical needs.

What are the kinds of HMOs which are operating in the Greater Metro Manila and adjoining provinces? There are nineteen Health Maintenance Organizations operating in this area. Of this number, sixteen are for-profit HMOs, two are pilot community-based HMOs and another is an employer-initiated HMO. HMOs started only in the late seventies or early eighties and are therefore still in their infancy stage. They cover around 400,000 members at the time of the study. A large majority of their members have been enrolled by their employers as part of a corporate enrollment.

For-profit HMOs usually employ a combination of staff and individual practice for private practitioners whom they contract to service their members for an agreed, pre-determined per capitation fee. These HMOs tend to be closely affiliated with either an insurance firm or private hospitals. They offer a comprehensive package of benefits for membership fees which are highly competitive.

HMOs are more advantageous than group health insurance as there is no out-of-pocket cost at time of need. This saves clients' anxiety about hospital bills or cost of out-of-pocket services when in need of doctor's services. Corporate clients, on the other hand see the HMO contract for service as one which they can end if they are not pleased with the service. They see it as enabling them to meet employees' out-patient and in-patient needs at less cost.

Community-based HMOs were developed as a pilot health care financing project. They are non-profit organizations. They have individuals and family groups as clients. They have much lower membership premium compared to for-profit HMOs as the range of choices of accredited providers is relatively limited. The benefit package available is comparable to those offered by for-profit HMOs.

Employee-Initiated HMO may be distinguished from for-profit HMOs in that it functions as a non-profit HMO. It serves only dependents of PAL regular employees. Half of the membership fee is paid by employees while the other half is paid by PAL Employer-initiated HMOs membership fees are higher than consumer based HMOs but slightly lower than investor-based HMOs. At the time of the research, it has been in operation for less than a year.

There are two plans which have government participation. The first is the tie up project between the PMCC and two HMOs, Health Card and Pamana. The PMCC has decided to proceed with it up to December, 1991 to work out administrative problems that beset the project.

Another health financing plan described in the study is the Makati Health Plan which is a four way partnership in funding health care for low income group at a local level. This program seeks to make quality medical care accessible to low income Makati residents and to all Makati municipal government employees. The municipal government of Makati, the Makati Medical Center staff and the members of the plan agreed to pool their funds, services and facilities together to forge a four cornered health financing and collaborative effort. The contract rate is negotiated on a yearly basis.

At the time of the research, there is no clear policy on how the state regards the operations of HMOs which are relatively new features of the health care financing scheme in the country. Legally, it is classified neither as an insurance or a pre-need plan.

As the number of HMOs increase, there is greater concern for looking into their operations. The suggestion that government look into HMO-client relations has been prompted mainly by the fact that as an organization that collects money in exchange for a promise to deliver services in time of need, HMOs are risk-bearing and fiduciary agencies. Moreover, as competition increases, prospective members clamor for more information on the performance of HMOs which they may use as a basis for making their choice to enroll or renew their contract. Some members likewise feel that they need some form of protection from unethical practices of some firms who mislead people into buying a product which they are not familiar with.

## **B. Areas for Policy Intervention**

Since it is still unclear as to who has jurisdiction or supervision over HMOs it may be useful for the Philippine government to establish some kind of framework most acceptable to those concerned through which:

- a) HMOs operations as a risk-sharing and service delivery mechanism are formally recognized;
- b) HMOs are distinguished from other forms of risk-sharing mechanisms;
- c) A minimum benefit package of health services to be delivered by HMOs is defined;
- d) HMOs can be held accountable both for their financial viability and for the adequacy and quality of medical services which their clients get; and
- e) information on HMO operations can be monitored and collected regularly.

What lessons can be derived from the state's intervention which led to the PMCC-HMO tie up project and the Makati Health Plan? These two plans have shown that, unlike market operations where forces of supply and demand and the firms' profit orientation strongly influence the price of services, the intervention of the government may lead to increased benefits to members at no extra cost. The state's negotiations in behalf of the relatively powerless and poorer population tend to improve the prospects for increased benefits, especially if a pool of resources can serve as a ready source of payment, as in the case of the PMCC.

Efficiency considerations will certainly distinguish between a better performing HMO and a non-performer. This may be crucial when one relies only on market factors. In dealing with firms like HMOs, however, more information beyond how they perform is certainly needed. A more sensitive issue could be how their clients see the timeliness, adequacy and overall quality of their services.

Without being limited to the two health financing schemes involving the Philippine Medical Care Commission and the Makati Health Plan, the Philippine government can address the question of how health care can be made more financially-accessible to those in the lower income classes through an examination of the following areas for policy intervention:

- 1) Since HMOs can only function for population with regular sources of income, schemes similar to the Makati Health Plan can be explored by financially viable local government units which can subsidize costs of providing health care services to families belonging to the lower income bracket.
- 2) Explore the possibility of big corporate employers assuming more of the burden of funding employees' health care cost so the state can use more of its resources for the lower income groups.
- 3) Support more efforts to develop area and group specific health financing schemes which enable groups, communities, the public sector, both local and national, to work together with the private sector either as provider of funds or of medical services.
- 4) On the basis of the outcome of the pilot consumer based HMOs and the PMCC-HMO tie-up project, assess the preparedness of local areas to initiate and sustain similar efforts through collaborative efforts involving community groups, local and national government agencies and the private sector.

The government has a strong role to play in promoting equity in a structure where inequities obtain. Where health resources are maldistributed, market forces may aggravate inequities further as a competitive market has the potential for exacerbating maldistribution when it provides incentives which



push professionals and services towards highly populated urbanized centers where people can afford to pay for their health needs. While we discussed the efficiency and the equity concerns as two distinct areas for purposes of setting the policy agenda for HMOs, it must be emphasized that there is a need for government to give attention and to link these two values together when it finally formulates and decides to take action on this agenda. Ultimately, only coordinated government planning and political will can ensure that equity is not sacrificed in the name of efficiency in the financing and delivery of health services in the Philippines.

The pioneering character of this study precluded it from venturing into any comparison of the relative value of HMOs or HMO-like firms vis-a-vis other forms of delivering and financing health care services. The empirical evidence in this field has been quite limited by the fact that a) the object of the research is considered to be still in its infancy stage and thus may be quite premature to evaluate, and b) more seriously, data on the internal operations of HMOs are not normally available to external researchers as these constitute critical trade secrets crucial in formulating policies on pricing, sales, benefit package, and members' access in a highly competitive and unregulated health services sector.

This is a first attempt to collect systematically information to depict the general character of HMOs. It sought to provide detailed accounts of how providers and members are brought together in what is hoped could be a mutually beneficial relation through a contractual arrangement and to enumerate the problems confronting the industry.

This study purposely avoided the use of a boundary setting framework which would have unduly restricted data collection. HMOs represent America's response to, among others, its health system's cost escalation problems. Thus, HMOs are products of an economic and political setting distinctly different from those prevailing in developing countries like the Philippines today. An open and less structured approach to the research was valuable in that it provided flexibility to capture the extent to which local conditions and practices, e.g., of delivering and financing health services, could influence the character of HMOs or HMO-like organizations in the Philippine setting. This is not to say, however, that we did not utilize the extensive literature on American HMOs in this study. The first part of this report clearly attests to the value we attach to understanding the North and Latin American experience as part of the process of describing and understanding HMOs and their possible roles in our national health care system. Fundamental questions on the number, processes and problems of HMOs had to be addressed in this study. However, having established these, bigger issues could be raised about the appropriate role that HMOs can play in the country's search for a health financing system which can respond to the growing needs under conditions of increasing scarcity and inequity. To link the findings of, and insights generated in the studies to those which will be undertaken later, it will be useful to establish a common set of criteria by which the various components of a national health financing system may be evaluated. These criteria, in a sense, reflect the norms which society expect this financing system to promote.

In this final portion of the study, one such set of evaluative criteria will be proposed as a way of suggesting the direction of future research on Philippine HMO. This can be done by determining what can be said about HMOs based on the data collected from this study and defining other information needs be collected to allow researchers to evaluate HMOs along this set of criteria.

### C. *The Beginnings of A Set of Evaluative Criteria*

As a starter, it will be helpful to consider what is available in the literature on evaluative criteria for assessing health financing schemes. Andreano and Helminiak proposed a set of six related criteria (ADB:1987, 281-284) which may be utilized in evaluating the performance of any alternative health financing/delivery mechanisms. The merits of any scheme may be established depending on how it achieves: a) health service production efficiency, b) health service utilization efficiency, c) funding efficiency, d) financial (funding) equity, e) health services distribution equity and f) intersectoral allocation efficiency. The focus of each of these criteria may be captured in the central questions they pose. Thus, for health service production efficiency, the question is to what extent is the health production process able to reduce the unit cost of production of individual health services. On financial or funding efficiency, the relevant question is whether the administrative costs of collecting and transferring funds are not greater than the amount generated. Utilization efficiency, which is also referred to as allocative efficiency, translates its three concerns, thus:

“ a) Are the most efficient modes of resource conversion to meeting health needs employed ?; b) Are given delivery modes being utilized by individual members of the population at optimal levels ?; c) Are modes of services directed to disease groups or populations groups where they can best diminish the constraining effect of disease on economic development of the country ?” ( ADB, 1987: 281 )

Financial equity or funding incidence asks the question as to who bears the burden of the cost of the services; while equity of health services distribution asks whether there is equality of access to health care for all. Finally, the search of intersectoral allocative efficiency asks to what extent aggregate level of funds in the health sector has been increased.

Do the results of this study put us in a position to rate HMOs through this set of criteria? It must be pointed out that our assessment of the status of HMOs in general, given our limited access to firm level data, must still be subjected to firmer validation through the collection of hard data generated from providers, (e.g., hospitals and physicians) members and HMO managers. While key informants in each of these sectors were interviewed for this study, our lack of access to data on the actual cost of operations, utilization patterns and similar information constitute the limitations of this study.

Given this caveat, however, we shall try to chart the future directions of research on Philippine HMOs through the use of five of the six criteria. We propose to do this by presenting a generalized assessment of HMOs given the data produced in this study. To validate this assessment, we shall identify other information which may be sought by future researchers to place this assessment on firmer empirical grounds.

Although three types of HMOs are described in this report, it must be stressed that this assessment will refer only to profit oriented HMOs as they cover a substantial and clear majority of HMO members in the Metro Manila area.

Market forces push HMOs to excessive price competition which directly translate to restrictions on the benefit package they can offer. With their marketing strategy relying heavily on those who control access to HMOs, i.e., commissioned insurance agents and brokers, members' understanding of the value of HMO services may not be directly compatible with the agents' or brokers' interest.

#### D. *The Research Agenda: Evaluating HMOs on More Solid Empirical Grounds*

How will investor-based HMOs rate along the five criteria of efficiency on health services production and service utilization, financial efficiency and financial equity as well as distributive equity?

*Financial Efficiency.* Financial efficiency is highest for insurance-based HMOs, servicing big clientele groups, who will have benefitted from the link up with an insurance system's nationwide network of offices and collection agents. Financial efficiency is lowest in newly established HMOs which does not have the same extensive collection and remittance network and are also burdened with having to develop an adequate number of members to ensure greater risk-sharing. Hard data on what percentage of HMO's administrative costs finance collection and transfer of funds cost within the agency are needed.

*Financial Equity.* At the firm level, HMO's built-in risk sharing among members and between members and providers lead to greater financial equity as cost of illness or services needed is spread over the healthy, the sick and the provider. On a national level, however, HMOs service groups who already have the advantage of social insurance and other corporate benefits. This situation exacerbates existing inequities between the employed and the unemployed. Data to show how much employers contribute to individual premiums in some agencies and how much of this, plus medicare coverage, account for actual health cost both for out-patient and hospitalization services will be needed. It will be interesting to compare data along this line among three sub-sets of the population: unemployed, employed without HMO membership and employed with HMO membership.

*Health Services Production Efficiency.* Generally, efficiency considerations of HMOs tend to result in lower cost per unit of service through the number and mix of services provided. Thus, hospital confinements, if not considered medically necessary, are not resorted to. Financial viability requirements of HMOs also demand that it closely monitors level of utilization of services by members. These practices tend to lower overall cost per unit of service and increase health service production efficiency.

In this regard, we need data on how Philippine HMO and non-HMO member's total medical service costs would differ in the production of specific medical services such as a hospital day or a physician office visit, as well as in the actual number and mix of services provided. Comparable sets of population who will require similar types of medical services may be compared in terms of their relative medical services costs.

*Service Utilization Efficiency.* Since medical services for HMO members are limited to those which the provider believes are medically necessary, there are supposedly less chances for over-utilization with a fairly even chance of under-utilization of medical services. Overall efficiency may be increased if there is no over-utilization but members may in fact suffer if there is under-utilization when providers are given incentives to under-utilize medical services. Data on whether less out-of-pocket cost for HMO members trigger greater demand for out-patient services in the Philippines will be an important input for evaluating Philippine HMOs along this concern.

*Distribution Equity.* HMOs tend to converge in areas where there are sufficient providers and medical facilities. This practice can aggravate existing inequities between urban and rural areas and therefore create more access problems for residents of these areas. It has been argued that HMOs' presence may cause more investments in other parts of the country if they serve to assure providers of a more regular

source of income. Philippine HMOs, however, are not directly investing in new medical facilities and are just beginning to develop primary care resources. By the nature of the clientele they service, HMOs in the Philippines tend to benefit mostly the employed in urban centers who also have access to social insurance and employees' compensation claims if disabled in line of duty. Future researchers will have to gather more data on whether HMO or non-HMO members' access to health services vary significantly in favor of the former. Moreover, variations of HMO or non-HMOs' access to medical services in rural or urban areas may also have to be established.

What lies ahead for HMO research? The greater need is definitely for hard data at the firm level that will allow us to truly assess the contribution of HMOs to the fulfillment of Philippine health financing objectives. Given the experience of this study, it is expected that this information will not be immediately forthcoming unless there is a properly constituted mechanism through which the appropriateness of HMO practices in terms of actuarial soundness, financial viability and liquidity and the cost and quality of medical services offered to members, are monitored.

An exciting and challenging future awaits researchers who may be interested in pursuing further studies on HMOs in the Philippines. With the growing attention now given to health financing concerns, nationally and internationally, the contributions of HMOs to developing countries' quest for greater efficiency and effectiveness need to be studied more closely in the context of these countries' search for the appropriate public-private mix in health care financing.

**Annex 1**  
**DIRECTORY OF HEALTH MAINTENANCE ORGANIZATIONS**  
**IN THE PHILIPPINES**

As of April 28, 1989

*BLUE CROSS CARE*

7th Floor, PB Com Bldg.,  
 6795 Ayala Avenue corner Herrera St.,  
 Makati, Metro Manila  
 815-08-36 to 45

*FAMILY MEDCARE*

6th Floor, Filipinas Life Bldg.,  
 6786 Ayala Avenue  
 Makati, Metro Manila  
 816-05-11

*FORTUNE MEDICARE, INC.*

Fortune Care Bldg.,  
 Dela Rosa St., near corner Amorsolo St.,  
 Makati, Metro Manila  
 819-12-03/ 819-12-25/  
 818-99-26/ 819-12-14

**HEALTH CARE & DEVELOPMENT CORP.**  
**OF THE PHILS.**

**Main Office:**

Perpetual Help Medical Center Bldg.,  
 Pamplona, Las Pin~as, Metro Manila  
 801-00-80/ 801-05-81 to 83/ 801-31-79

**Makati Office:**

Suite 255 Cityland Condominium IV  
 124 Valero St., Salcedo Village,  
 Makati, Metro Manila  
 817-51-72/ 819-15-05

*HEALTHKARD INTERNATIONAL, INC.*

1755 Taft Ave., Malate,  
 Metro Manila  
 59-94-49/ 521-04-40/ 521-90-11

*HEALTH MAINTENANCE, INC.*

5th Floor, Merchants Bldg.,  
 Sen. Gil Puyat Avenue,  
 Makati, Metro Manila  
 85-34-76/ 86-40-81

*HEALTH PLAN PHILIPPINES, INC.*

Suite 206 Limketkai Bldg.,  
 Ortigas Avenue, Greenhills,  
 San Juan, Metro Manila  
 721-00-25 to 26/ 721-00-25 to 29  
 & 30/ 78-07-69

*INTEGRATED HEALTH CARE*  
*SERVICES, INC.*

3rd Floor Medico Bldg.,  
 San Miguel Ave. corner Lourdes Road  
 Pasig, Metro Manila  
 673-22-81/ 673-22-89

*LIFECARE*

8th Floor, Minor Wing, Don~a Narcisa Bldg.,  
 8751 Paseo de Roxas, Makati,  
 Metro Manila  
 810-46-66 to 69

*MAXICARE*

Room 500, Kalayaan Bldg.,  
 164 Salcedo St., Legaspi Village  
 Makati, Metro Manila  
 810-58-97/ 810-72-86/ 817-73-16

**MEDICARD**

9th Floor, Sagittarius Bldg.,  
H.V. Dela Costa St., Makati,  
Metro Manila  
819-34-71/ 815-32-35/ 815-32-66

**PAL DEPENDENTS' MEDICAL PLAN**

PAL Dependents' Medical Plan Clinic,  
Medical Sub. Dept./Personnel  
Andrews Ave., Nichols  
Pasay City  
832-33-41

**PAMANA GOLDEN CARE**

3rd Floor, Solid Mills Bldg.,  
De la Rosa St., Legaspi Village,  
Makati, Metro Manila  
818-32-59/ 818-70-36/ 818-18-94

**PHILAMCARE HEALTH SYSTEMS, INC.**

Philamlife Bldg., United Nations Avenue  
Metro Manila  
521-63-00/ 59-93-47

**ST. PATRICK'S CLINIC  
& LABORATORY, INC.**

642 Shaw Blvd., Mandaluyong  
Metro Manila  
79-05-07/ 79-13-37/ 70-10-86 to 87

**ST. VINCENT HOSPITAL  
MANAGEMENT INT'L. INC.**

4th Floor Century Towers,  
100 Tordesillas St., Salcedo Village  
Makato, Metro Manila

**WATEROUS MEDICAL CORPORATION**

Waterous General Hospital  
166 Pilar St., San Juan  
Metro Manila  
79-13-98/ 79-42-94/ 70-59-59

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