

Health Care Financing Reform: *Issues and Updates**

The matter of instituting a more efficient financing program is a very crucial part of health care reforms. This is so because financial resources are insufficient to pay for health care services for the people, especially the poor who constitute more than 40 percent of the population and many of whom are not covered by any health care insurance program. Availability, access and affordability of health care services are issues that are both overwhelming and complex as health care is essential to the people's survival and productive living. As such, it is a never-ending responsibility for fami-

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lies and also for the government. This interminable need for health care services takes on a more urgent tone with the rapid growth of the population and escalating costs of services.

With health care being such an enormous undertaking, financing it is an equally intricate matter. The solution is not as simple as raising more funds as the experience of Korea and Taiwan indicate: additional funds will only be dispersed quickly within health care systems that have not adopted measures that can make optimum use of resources. In addition, more funds may mean greater possibility of abuse by households and health care providers. Thus, health care financing programs must be designed in such a way that would maintain the balance of enhancing the efficiency of health care service consumption and production while expanding the coverage to a greater number of people, including those who belong to the informal sector. *The challenge of health care financing, therefore, is to generate more funds and use them wisely and efficiently.*

Certainly, overcoming the challenge is not as easy as it sounds. Issues and concerns surrounding health care financing are myriad and require extensive research. In this regard, the Department of Health (DOH) has been

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at the forefront of efforts to come up with the right approach in pursuing health care financing reforms. Joint undertakings with other government agencies such as the Philippine Institute for Development Studies (PIDS) have been accomplished which resulted in the completion of 23 studies under the Baseline Policy Research for Health Care Financing Reforms project. The integrative report of this project entitled “The Challenge of Health Care Financing Reforms in the Philippines” written by UP School of Economics Professor Dr. Orville Solon and his associates was largely the source of information for this *Policy Notes* issue. These baseline studies as well as those sponsored by private entities such as the Asian Development Bank and the United States Agency for International Development have contributed much to policy research and subsequent inception of health care laws in the country. Roundtable discussions are periodically held as the DOH continues to pursue reforms that would achieve better delivery of health care services and ultimately, improve the health status of all Filipinos.

Health Care Financing

Rationale/theoretical framework

As the government sought to effect reforms in the health care service by replacing the Medicare program with a more comprehensive system of national health insurance, questions arose as to why it had to be altered at all. “Why fix something that is not broken?” was the common reaction to the changes. But the DOH recognized that they are necessary to make health care services more responsive to the people’s needs.

Toward this end, the health care community must make a collective effort to realize several goals, the ultimate of which is to improve the health status of all Filipinos. As stated earlier, generating funds is only part of the solution. The rest lies on the actual use of preventive, promotive, curative and rehabilitative health care services which improve health.

The intermediate goals of health care financing are fourfold¹:

- * to provide for sufficient funds especially for the unmet needs of the health care system;
- * to improve access to health by the most disadvantaged members of society;
- * to attain sustainability by formulating policies that are sensitive to the changing socioeconomic, demographic and epidemiological conditions in society; and
- * to gain value for investments.

These goals should translate to the achievement of the broad objectives of an effective health care financing package which consists of:

- * quality, effective and accessible health care services;
- * affordable, equitable and sustainable financial plan;
- * incentives for cost containment in the delivery of health services;

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- * enhanced and efficient organizational structure; and
- * informed/empowered choices of the key participants in health—the beneficiaries/consumers, funders and providers.

State of health care financing

Financial resources for health care in the Philippines have been shown to be sorely insufficient. A study com-

¹Further discussed in Chapter 2 of “The Challenge of Health Care Financing Reforms in the Philippines.”

paring the health care spending of ten countries in the Asia–Pacific region done by the World Bank (World Development Report 1993) revealed that the Philippines had the second lowest per capita health expenditure. The country was also ranked second lowest in terms of health expenditure as percentage of gross domestic product (GDP). The two percent of the GNP that was being allotted to national health care funding does not even come close to the World Health Organization (WHO) standard of at least five percent. Developing countries spend four percent of their GNP on health while Europe and Japan set aside 7 to 8 percent; the United States is the highest with 12.4 percent and the rest of the world puts in an average of 7.5 percent on health care. There was also not much of an improvement in government health spending from 1978 to 1993. Thus, it was concluded that because of inflation, the country was spending even less on health in real terms.

In the analysis of the composition of the country's source of health care expenditures in 1991, it was found that a big chunk came from direct payments of households which accounted for 38 percent. The biggest source was still government which had 49 percent of the total health expenditures, with the national government easily getting 42 percent and the local government 7 percent. The rest came from Medicare (10 percent) and voluntary contributions (3 percent) to private health insurance companies.

These figures mean that the bulk of the burden of the costs of health care still falls on the shoulders of individual families/households through out-of-pocket payments. The government's budget for health also came from the public through direct and indirect taxes while Medicare contributions are deducted from individual incomes.

Recent efforts on health care financing

Primary Health Care Program. In 1983, the DOH introduced the Primary Health Care (PHC) Program in selected locales aimed to put more emphasis on preventive rather than curative health care treatment. In par-

ticular, these included the Botika sa Barangay, Cooperative Health Care in selected provinces, livelihood projects and community-based health management organizations (HMOs) in San Antonio, Nueva Ecija, Biñan and Diliman. By stimulating the shift from physician-dependent and curative-oriented care to health promotion and disease prevention, the PHC made gains in increasing the effectiveness of the health care system.

Major study projects: ADB, PIDS and USAID. In an effort to pursue reforms more vigorously, the DOH then undertook major study projects with public and private entities on the Philippine health care system. In 1987, the Asian Development Bank First Country Study on Health Care Financing investigated the sources and uses of health care funds and estimates of total national expenditures for health care. In 1990, the DOH forged a joint project with PIDS which produced 23 baseline studies on several major issues in the health care system: consumers, manpower, hospitals and other health care facilities, and health care financial institutions such as insurance, private sector, public investment and community efforts. In that same year, the USAID funded the Health Finance Development Project whose benchmark studies delved on national health insurance, devolution, public resource management, standards, licensing and regulation, and health policy development.

Devolution of health services. It also helped that the Ramos administration early on in its assumption to office in 1992 fast tracked the implementation of the devolution of social services including health care into the hands of local government units (LGUs). The DOH phased the decentralization into three: the first was the transfer period which occurred in 1993; the second phase is the transition where the DOH is currently at the home-stretch; and the final stage is where stability is expected to have set in.

The devolution of such a major responsibility as health care is seen as a further boost to health care reforms with the assurance of more local level resources

for health. The DOH budget is divided into four, with the provincial, municipal, city and barangay levels each getting a piece but the first two are the ones that get a substantial share: 46 percent for the provinces and the municipalities take 47 percent.²

This move is supposed to enhance the delivery of health care services as command and control had been decentralized. It is also aimed at developing local initiatives and enabling LGUs to formulate their own programs to address their localities' health needs. Since devolution is still ongoing, the DOH is planning to inject innovations that would address certain problems that have risen and further refine the process. One such proposal is to give grants to LGUs that have performed well in terms of health services and impact performance. Another is for Congress to set up a national assistance fund that would subsidize the salaries of health workers and enable LGUs to use the remaining budget to enhance their health facilities.

Passage of NHIL and Creation of PHIC. The devolution became the foundation for the National Health Insurance Law (NHIL) which created the implementing arm that is the Philippine Health Insurance Corporation (PHIC). The NHI scheme aims to provide social health insurance under the principles of social solidarity, equity and promotion of quality health services. It not only endeavors to improve health care delivery to all Filipinos but also seeks to mobilize the active participation of the community. Based on several pillars, the NHI program is committed to provide health insurance coverage under two systems: a subsidy system for those who cannot afford to pay and a system of payment for those who can afford to pay.

Medicare may have been of some benefit but the main problem was that it only covered those who were

employed and based in the urban areas. Coverage also only accounted for 40 percent of incurred expenses. It is now the challenge of the PHIC to cover the informal sector—those who are not regularly employed and as such do not have regular income—especially those in the rural areas. The same concerns may be said of private health insurance companies whose clientele are mainly corporate employees

Unlike Medicare, the NHIP provides quality assurance of health care by giving enough clout to the PHIC to serve as both a guarantor of quality health care and a regulator of health care institutions. Fraud control is another main pillar of the NHIP, as a reaction to the Medicare's alleged history of overutilization and abuses. However, since the NHI is still at its initial stages of implementation, it is fraught with massive problems that involve operational functions and concerns. Such issues will be discussed later on.

Private health insurance industry. Owing partly to the inadequate services and benefits of Medicare and inefficient care in public hospitals, the private health insurance industry grew and proliferated. Those who can afford it opt to pay private companies in exchange for the assurance of quality health care services that are being offered.

The private health insurance companies are categorized into four, namely:

- * commercial indemnity firms (life insurance companies) – those that provide health and accident insurance
- * Health Maintenance Organizations (HMOs) – firms that combine the provision of health services with financing
- * employer-provided health benefits – a lot like HMOs but are more lenient about certain procedures such as the use of nonaccredited service providers
- * community-based health financing groups – limited contributions are pooled and made available to augment members' medical expenses.

²Data taken from the Executive Summary of the Roundtable Discussion on "Stimulating health care reform from the 90s to the next millennium: the role of the National Health Insurance Law and recent policy changes."

Issues/Concerns

Behavioral factors

The basic concept of health care financing is to enable a person to use health care services regardless of his current ability or inability to pay. To achieve it, people must be made to understand the importance of health insurance and the value of prospective benefits that will

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be derived from being insured for health. Investments poured into health insurance assure households of health care coverage when they get sick. The inevitability of needing health care must therefore be fully emphasized since there is much reluctance to avail of health insurance because people do not immediately see the "goods" that they pay for.

Coverage: voluntary vs. compulsory

Expanding the coverage of health insurance is deemed double-edged. If membership were to be made voluntary, health care providers may resort to adverse selection or cream-skimming. They will only cover those who are generally healthy, have no history in the family of a congenital ailment or are not in a hazardous profession. They will not cover clients who may have to use the services often and thereby quickly deplete the resources. Thorough screening and examination will ensure that only those who are healthy and have no history of major ailments will be granted insurance. On the other hand, making it compulsory may lower the quality of benefit packages to cover a great number of users. Conversely, insured funds for services may also lead to administration of unnecessary treatments and tests which may escalate the costs of health care.

Government must certainly come up with the right approach in order to eliminate the possible areas where abuses may occur.

Efficiency: operational problems

The problem with PHIC. It is well known by now that the PHIC is going through very rough initial problems regarding its operations. Since it took over the collection of health insurance payments from the Government Service Insurance System (GSIS) and Social Security System (SSS), it has been beset with complaints from privately-owned hospitals which started in Mindanao and spread to other parts of the country. Apparently, the PHIC has not been reimbursing the hospitals the Medicare portion of the expenses incurred by patients. Hospitals are asking for amounts that range from P500,000 to as high as P12 million. The PHIC has responded by saying that part of the problem lies with the issuance of new guidelines which the hospitals have yet to abide with. The hospitals, in turn, have responded by saying that these new guidelines were not immediately made known to them and thus, they were not able to abide by them promptly. The PHIC also admitted that payments have indeed been delayed because of operational problems within the organization, e.g., the institution is severely undermanned (some sources have revealed that more than 700 positions have yet to be filled).³ Whatever the reasons, hundreds of hospitals all over the country have started to boycott Medicare until the PHIC reimburses their expenses.

The PHIC must also research further on several vital issues that include:

- * how to achieve universal coverage;
- * how to ensure quality for a given cost;
- * how to ensure efficiency in utilization;
- * the impact of LGU financing capability on the indigent program and expansion in benefits;
- * expansion and equalization of benefits;

³"The Problem with Philhealth" by Dr. Ed Clemente in his column Health Economics, *Businessworld* Vol. XI, No. 250, July 17-18, 1998.

- * merger of health insurance funds; and
- * ways to improve benefit and premium setting.

Beyond the initial problems concerning operational systems, the priority concern of the PHIC should be to ensure the sustainability of the program in the face of its enormous mission and high expectations.

Sustainability: Not just a matter of collection. A major challenge of any health insurance scheme is how to achieve sustainability in the long run. One of the main steps is to have an efficient collection system. The problem may not be critical with respect to employer-provided health benefits, volunteer contributions or even national health insurance. But to community-based health care schemes, the matter of collection is crucial as it determines if the scheme will be sustained or not. As such, many community-based health care financing projects have folded up due to the failure to collect from members. It is not only a matter of keeping tabs on the money collected but again, goes back to the willingness and ability of members to pay premiums in view of poverty and the mindset that discourages them from paying for services they do not yet see.

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Policy Recommendations

Areas for action

Enhancing the PHIC. Apart from resolving the immediate issues such as remittances and operational systems, the PHIC has three main tasks to focus on:

- * Exercise prudence by keeping funds secure and sustainable and not spending more than what it has.
- * Introduce technical efficiencies in order to increase the indigents' benefits. Part of this is getting rid of fraud, introducing innovations in the way providers are paid, and exercising the market power of a large buyer of services.

- * Ensure equity by using the funds provided to it and the realized savings to increase the indigents' benefits.

Regulating the HMOs: Senate Bill No. 2116. The rapid growth of the private health care industry, particularly indicated by the proliferation of HMOs, prompted the government to focus more attention on this trade amid calls from some sectors for the adoption of laws that would regulate them and protect the interests of their clientele. Thus, then Senator Ernesto Maceda introduced Senate Bill No. 2116 otherwise known as the "Health Maintenance Organizations (HMOs) Code of 1997" which seeks to "provide affordable health care services, through the HMOs, regulating their operations, and for other purposes." The Bill is still awaiting approval.

Invoking Article II, Section 15 of the Constitution that declares the State's responsibility to "protect and promote the right to health of the people and in-still health consciousness among them," the Bill cited that one of the ways to reach this goal is to "enhance the accessibility of affordable health care services by encouraging the growth of medical/health service providers and by regulating their activities to prevent the commission of fraudulent acts inimical to the people."

It may be seen as a move to take control and keep watch over private health insurance companies but based on its statement of policy and objectives, the Bill is not solely after regulating the HMOs. It recognizes the role that the private sector in general plays in the common undertaking to provide and deliver health care services to the people. In this regard, the Bill vows to "tap the participation of the private sector in providing, funding and managing health care services through the HMOs" in order to "assist the government in the efficient delivery of quality and cost-effective basic health care services."

Recognizing the importance of nurturing the growth of HMOs, the Bill also seeks to grant them incentives. These include reduced customs duties for imported medical equipment; exemption from percentage tax, documentary stamp tax and VAT; and making health care membership fees paid by employers deductible from taxable income. These incentives are aimed to lower the cost of health care and encourage companies and employers to provide health care plans for their employees.

On the other hand, the Bill also realizes the possibility that fraud and abuse may inhabit such a profit-generating system. It therefore seeks to pursue the establishment of a regulatory framework to “protect the rights of the buying public. . . of HMOs, their members and health care service providers.” These include strict licensure requirements that new and existing HMOs must comply with. Information on capitalization, financial standing, membership, health care services offered and even geographical area of operation of HMOs are to be indicated. Grounds for suspension of license are also indicated which cover financial infirmity, violated agreements with members, false information and disregarded arbitration decisions. Licenses may be finally revoked once repeated violations may be proven. The DOH has been designated as the supervising and regulating agency over HMOs should the Bill be enacted.

Accrediting community-based health financing schemes. There are also moves to accredit community-based health financing schemes through the Philippine General Hospital. In the same vein that HMOs are being recognized through Senate Bill No. 2116, this move is also seen as a means to assist the government provide low-cost health care insurance programs especially for those living in the rural areas. A number of community-based health financing schemes are already existing in the countryside but some are in danger of failure due to their vulnerability to resource dissipation because of limited client base and premiums.

Reinsuring the insurers. In response to the problems being faced by small private health companies in-

cluding community-based health financing schemes, health policy experts suggest that they be insured by the PHIC. They will be required to pay premiums to the corporation in exchange for insurance benefits when large amounts of funds are urgently needed by their members. With this fall-back measure, these companies will be sustained and government may encourage other communities or sectors to establish their own health financing schemes.

Proposed strategy for implementation

The role of DOH. With devolution, the role of the DOH may seem to have been diminished. Still, the DOH remains the lead government agency that will determine the course of the government’s health care program. Since the DOH and LGUs are now supposed to be in partnership, it is important to know at what level the community has been able to have their programs develop further. However, there are gaps in communication and information dissemination. This problem should be addressed. Local government chiefs should develop an understanding of primary health care and how it should be enhanced in their localities. The DOH should be able to guide the LGUs on how they can go about utilizing their financial resources to achieve the purpose of better health care services. And since the PHIC is under the supervision of the DOH, the Department should also ensure the efficiency of its operations. After all, the NHIP’s success lies on its (DOH) hands.

The role of the Health Policy Development Staff (HPDS). The pursuit of health care financing reforms clearly needs more research to attain the appropriate approach and policy framework. It is in this regard that the HPDS is at the helm of efforts. With the entry of the new administration including at the DOH itself, the HPDS is expected to provide the new leadership constant vigorous policy research on a concern that is as important as health care financing.

The role of PHIC. In the implementation of the national health insurance program, the PHIC’s role includes the development and enforcement of quality health care

standards. This will facilitate the provision of optimal care to its beneficiaries. PHIC will also provide beneficiaries with care plans based on accurate, complete and useful information. Access to appropriate care at the right time is another important task which includes the guarantee of consumer participation in health care decisionmaking. The PHIC shall also respond to community needs by reaching out to all constituents including the underserved and special needs population like the disabled. The PHIC shall also not discriminate against any consumer or provider enrolment, in the provision of quality health care, or in ensuring access to health care.

The PHIC as the implementing arm of the national health insurance program shall strive to become a high performing corporation that is efficient, effective and responsive to the needs of its beneficiaries.

Conclusion

The less-than-healthy state of health care financing system in the Philippines may be seen to run parallel to the people's own health status. In which case, much treatment and rehabilitation are needed in the form of policies and programs that will address the weak areas and realize the mandate of health care in the country.

Much has already been done in this regard. The various research projects that the DOH has undertaken with other government agencies and private organizations have contributed a lot to policy reforms including the inception and passing of the National Health Insurance Law and subsequent creation of the PHIC. This is perhaps one of the most significant advancements toward better health care service with the assurance of universal coverage in 15 years and enhanced system of benefit claims. The devolution of social services including health care to LGUs and rise of HMOs have also added momentum to the thrust of the DOH to involve the local governments as well as the private sector in the common effort to provide better health care service to the people.

Still, more needs to be done as indicated by the problems that have risen in the implementation of the

NHIL and devolution. The requisite adjustments are needed to smoothen rough spots and fill in the loopholes that such an overwhelming and intricate responsibility as health care financing is bound to have. Through it all, the DOH remains confident that its adopted themes, "Health for All" and "Health in the Hands of the People" shall be realized.

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