Department of Health HP Notes Health Policy Notes

Health Policy Notes

Volume 6: Issue 1 (November 2009) |Department of Health, Manila, Philippines

"Health Sector Performance on Health Financing: Are we progressing towards equitable and efficient financing for health?"

Introduction:

The goals of health financing is to ensure that funding for health care is available and to establish the right financial incentives to health care providers so that all individuals have access to effective public health and personal health care. (WHO, 2000). The health financing reforms under the Health Sector Reform Agenda were set amidst the scenario of high out-of-pocket expenses for health and problems with the National Health Insurance Program specifically on inadequate benefit support with bias towards in-patient care, limited population coverage, and weak benefit delivery and provider payment mechanism. To address these problems, HSRA sought to implement strategies that include: 1) improving the benefits of NHIP to make it more attractive; 2) aggressively enrolling members; 3) introducing measures to improve program performance; and 4) establishing administrative infrastructure that can handle the increased work load.

Implementation of Health Financing Reforms

Although substantial efforts have been put into implementing the financing reforms as articulated in the HSRA, health financing strategies have yet to be fully implemented and much broader and comprehensive health financing goals have yet to be attained. The following summarizes the implementation of health financing strategies that have been set in 1999 and improved through time.

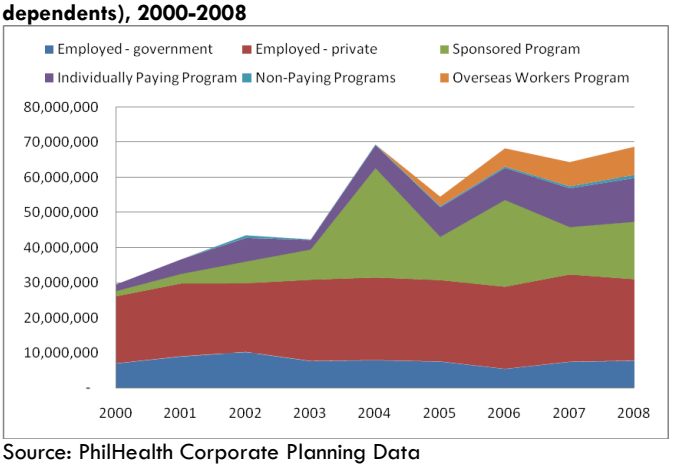
1. **Improving NHIP Benefit Package.** Table 1 shows the evolution of PhilHealth Benefit Package through time.

Year	NHIPBenefits
1996	Increases in benefit package: 50% for SSS; 25% for GSIS; 50% for OWWA
1999	50% increase in benefit ceiling for private and public sectors; 75% increase for indigent members; unified benefit package
2000	Out-patient benefit package through capitation
2002	Increase in some benefit items: 34% increase in drugs and medicines and 45% for x-ray and laboratory
2003	Increase benefits for room and board; launched TB DOTS, Maternity, SARS and Dialysis Package Benefit Packages
2004	Quality Improvement Development Studies – piloting of zero co-payment for pediatric in-patient care and pay for performance for health providers
2005	PHIC assumes the management of OWWA medicare benefits
2006	Newborn Care Package and preoperative tests in elective surgery
2007	Revision of case typing system; unified benefit schedule for all PhilHealth members including OWWA; Sets the general rule of fixed case typing
2008	Malaria Outpatient Package and Voluntary Surgical Contraceptive Procedures
2009	Normal Spontaneous Delivery and Maternal Care Package; tiered professional fees, P 100 for take home medicines, cataract package and revised value scale

Source: DOH Health Policy Notes Vol. 5 Issue 4 July 2009

2. **Aggressively enrollling members to PhilHealth**
The essence of the NHIP is to expand the social health beyond the formally employed sector. Consistent with this, HSRA specifically identified the strategy of agressively enrolling the sponsored and the individually paying members. Between 2000 and 2008, Sponsored Program (SP) membership showed a percentage increase of 933% while the Individually Paying Program (IPP) had percentage increase of 556%. Figure 1 shows the progressive increase of all types of PhilHealht members through the years.

Figure 1. Active PhilHealth beneficiaries (members and their dependents), 2000-2008



Source: PhilHealth Corporate Planning Data

3. **Introducing Measures to Improve Program Performance**
While administrative efficiency, increased support value and ability to cover the real poor can also be part of a performance analysis, HSRA only set the targets for improvements in NHIP performance in terms of the Program's capacity to generate resources and expanding the accreditation of health providers,.

Secure funding is critical to implement the necessary improvements in NHIP. Through the years, PhilHealth made efforts to mobilizefunds from other tax revenues such as the Documentary Stamp Tax Law, excise tax-related laws and the Bases Conversion and Development Act. However, Philhealth was never given the opportunity to manage these as trust funds instead these were incorporated in the GAA allocation for PhilHealth.

In terms of premium contribution structure, the salary cap of P5,000 was raised to P30,000 but this is still considered regressive for people with monthly salaries pf P30,000 and beyond. The contribution structure continues to put pressure on low income families.

Aside from increasing and securing funding to support the NHIP, the HSRA also identified expansion of accreditation to other facilities and service providers and strengthening quality assurance of the services covered by PhilHealth. PhilHealth has expanded the accreditation of facilities from hospitals and RHUs to other facilities like Ambulatory Surgical Clinics, TB DOTS centers and Maternity Care Clinics; and, in more recent years the inclusion of other health providers like midwives (Table 2). Among the accredited hospitals, 61% are privately owned and only 80% are government hospitals.

Table 2. Number of PhilHealth Accredited Facilities and Professionals, June 2009

Accredited Facilities and Professionals	Number
Facilities	
• Hospitals	1,558
• Rural Health Units/ Health Centers	1,086
• Ambulatory Surgical Clinics	36
• Free-standing Dialysis Centers	30
• TB DOTS centers	554
• Maternity Care Clinics	470
Professionals	
• General Practitioners	10,654
• Medical Specialists	11,544
• Dentists	196
• Midwives	285

Source: PhilHealth Stats and Charts, June 2009

4. Developing administrative infrastructure to manage the increased workload.

While innovative efforts have been done to improve the administrative infrastructure of PhilHealth including expansion of the accredited collecting agents to 4,048 nationwide (as of June 2009), several areas remain unchanged or wanting of much improvement such as establishing the accreditation mechanism for RHU and TB DOTS Centers and using capitation scheme as the main provider payment mechanism for outpatient benefit packages. Delays in investing on a full management information system has also hindered several of its cost containment functions including fraud control, efficiency in claims processing, membership control, and benefit expenditure monitoring.

5. The F1 Health Financing Reforms

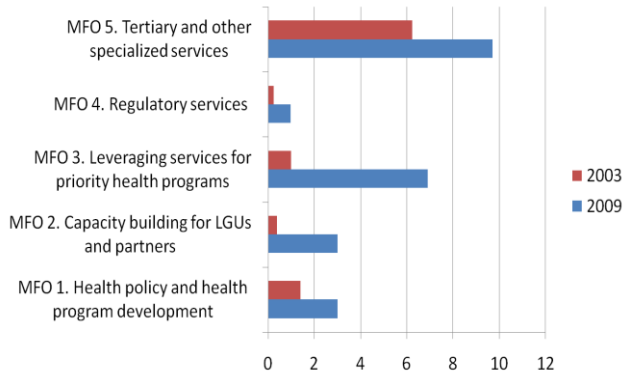
Recognizing that health financing reforms can be strengthened by complemetary reforms, FOURmula One for Health identified other strategies to strengthen the health financing system including: *mobilizing resources from extrabudgetary resources; coordinating national and local spending for health; focusing direct subsidies to priority health programs and adopting performance-based financing system.*

Mobilizing Resources from Extrabudgetary Resources. In 2005, the DOH started to adopt the Sector-wide Development Approach for Health (SDAH) to health sector reforms, which aims to 1) reduce the fragmentation of support of development partners; 2) sustain institutional development by using government systems and procedures; and 3) reduce transaction costs of the government in dealing individually with donors and partners especially in planning and evaluation process. While the National Economic and Development Authority (NEDA) recognized the health sector's achievements in coordinating donor funds, not all donors have been integrated into the SDAH framework. (David and Geronimo, 2008)

Coordinating National and Local Spending for Health. The DOH has first developed the Health Sector Expenditure Framework (HSEF) in 2005. HSEF was made possible through closed engagement and and negotiations with the Department of Budget and Management (DBM). It defined the amount of resources available from the national to the regional level and the corresponding allocation to health programs and institutions. HSEF ensures consistency of expenditures relative to the core functions of DOH and its desired organizational outcomes based on the Organizational Performance Indicator Framework (OPIF). It also provided the basis for the formulation of the Budget Strategy Paper by DBM in 2006. HSEF and Budget Strategy Paper resulted in the subsequent increase of the DOH budget allocation (Figure 2). At the local level, the Province-wide Investment Plan for Health (PIPH) articulates the investment requirements of provinces and their component municipalities. The DOH helps mobilize resources for the PIPH through the following process:

1) The resource requirements of the Provinces are identified in the Annual Operations Plans of the PIPHs.
2) These are discussed with the CHDs, and the CHDs try to reconcile the requirements of the various provinces with the available resources.
3) The requirements are then deliberated by the Joint Appraisal Committee. Some funds are sub-allotments from the DOH central office while some are provided by the CHD directly to the provinces. In addition some donors also provide support through the DOH-Province Memorandum of Agreement and Service Level Agreements (SLAs).

Figure2. DOH Budget by Major Final Output, 2003 and 2009 (in Billion Pesos)



Focusing Direct Subsidies to Priority Health Programs through Performance-based Financing System.To direct subsidies to priority programs, performance-based budgeting (PBB) was adopted in 2006. PBB for public health prioritizes public health programs that contribute directly or indirectly to the attainment of desired health outcomes. Priority health programs are identified based on burden of disease, equity, economic efficiency, and cost effectiveness and these are reviewed every two years. Similarly, a performance-based budget for hospitals was also adopted in the same year. Although the policy articulates the allocation scheme that would provide performance incentives to motivate the hospital staff to perform better and to proactively set effective business and financial management, the impact of this policy on the quality of hospital services and efficient use of limited hospital resources remains to be seen.

Assessing the Impact of Health Financing Reforms

The goals of health financing system focus on providing financial protection, ensuring equitable financing and access to health services, universal coverage and efficient use of financing for health care. These goals are articulated in HSRA 1999-2004, National Objectives for Health 2005-2010 and FOURmula ONE for Health 2004-2010 (Table 3). Although targets have not been consistently identified across the three documents, Table 3 shows selected indicators for health financing reforms based on the National Objectives for Health 2005-2010.

Table 3. Selected Indicators and Targets for Health Care Financing

Indicator	Baseline	Target	Latest Data
THE as % of GNP	2.9% (2003)[a]	3-4% GNP (2010)	3.1% (2005)[b]
Total Government Expenditure as % of THE	34.2% (2003) [a] 16.7% National 17.5% Local	50% (2010) 18% National 22% Local	28.7% (2005) [b] 15.8% National 12.9% Local
Total Social Health Insurance as % of THE	9.5% (2003) [a]	15% (2010)	10.7% (2005) [b]
Total Public Health Care Expenditure as % of THE	12% of THE (2003) [a] 4% National 8% Local	20% (2010)	11.1% (2005) [b] 5.1% National 6% Local
Established performance-based financing system for hospital, public health program and regulatory agencies	Performance-based financing strategyinitiated (2005)[c]	Institutionalized performance-based financing system	Performance-Based Grant Systems for MNCHN, 2WHSMP and KfW-HSRP (2009)
Establish Sector Development Approach for Health	SDAH system initiated (2005) [c]	SDAH system established	JAPI JAC Review Partners' Meeting (2008) [f]
Out-of-pocket expenditure as % THE	44% (2003) [a]	20% (2010)	48.4% (2005) [b]
% coverage of total population	81% (2004)[d]	85% (2010)	76.2% (2008)[d]
Average% of benefit support value	74% (2004) [d]	80%	42% (2006) [f]
Progressivity of Premium contribution	15,000 for formal sector 1,200 for IPP (2004) [d]	30,000 for the formal sector Different premium rates for IPP	30,000 salary cap approved (2004) IPP tiered premium initiated (2005)
% of accredited health facilities offring OPB	31% of RHUs are accredited	80% of RHUs (2010)	46% (2009)

THE – Total Health Expenditure; JAPI - Joint Assessment and Planning Initiative; JAC - Joint Appraisal Committee

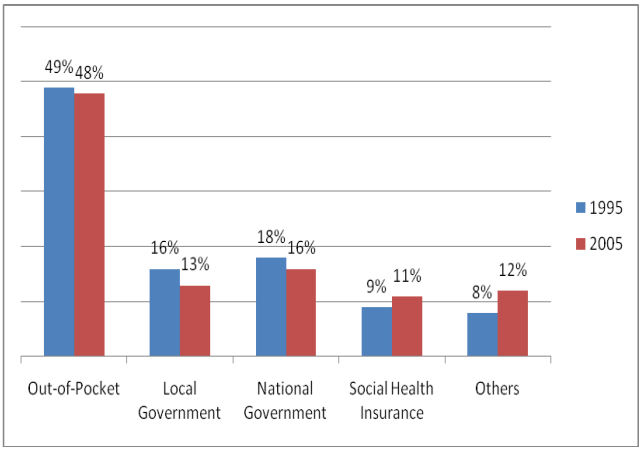
Sources: [a]PNHA, 2003; [b]PNHA, 2005; [c] DOH, 2005; [d] PHIC, 2004; [e]PhilHealth Corporate Planning Data; [f]David & Geronimo, 2008

A. Financial Risk Protection

Financial protection is established when individuals or households are prevented from becoming impoverished or poorer by the costs of utilizing health care. This is assured though a fair financing system wherein the risks each household faces due to the costs of health care are distributed according to the ability to pay rather than to the risk of illness(WHO, 2000). Fair financing can be achieved by minimizing the share of out-of-pocket as source of financing the health system and establishing a prepayment mechanism that is progressive in terms of household income.

While reform efforts are being implemented over the years, the financing system remains dependent on regressive and financially risky out-of-pocket sources (Figure 3). Analysis of Annual Poverty Incidence Survey data shows that the average out-of -pocket expenditures of households for medical goods and services represent 82% of the total health bill, and can go as high as 94% among the poorest households. (Quimbo and Panelo, 2009). Prepaid financing are still below the NOH targets of 15% for social health insurance and 50% for government (national and local) share over the total health expenditures.

Figure 3. Distribution of Health Expenditure by Source of Funds, 19952005



Source: NSCB data

B. Universal Coverage

Philhealth provides coverage for 76% of the population. However, issues such as double enrollment and irregularity of premium payments particularly among IPP and SP members may lead to over estimation of the percentage of PhilHealth beneficiaries (members and their dependents) over total population. Moreover, the current counterparting system of premium contribution for the SP between the national and local governments has led to inconsistent enrolment level of the SP (Figure1). Among the IPP members, the heterogeneity of this group vis-a-vis a flat premium contribution has proven to be regressive. Idetifying them and categorizing them for appropriate premium payment scale continuously poses a challenge to PhilHeath.

C. Equitable financing

The current health financing system remains inequitable as OOP continued to be largely unchanged between 1995 and 2005 (Figure 3). While premium contribution among the formally employed is based on the salary and thus offered some form of progressiveness up to PhP 30,000 monthly salary cap, there is no fair contribution among the IPP, SP and Overseas Workers Program (OWP) members since they continue to have a flat premium contribution.

D. Equitable access to health services

Allocation of health resources for the poor has been a priority of this administration. This is well reflected by increased enrollment of indigent families to Sponsored Program. However, PhilHealth utilization rates by SP members are low, ranging from 1.69 to 1.83 between 2002 and 2006, as compared to IPP members whose utilization rates shot up from 2.02 in 2002 to 7.27 in 2006. (Quimbo and Panelo, 2009). Moreover, the distribution of accredited health facilities and health providers are more concentrated in the urban areas, leaving the poor in the rural and geogrpahically isolated areas with poor access to health care.

E. Stengthening Operational Efficiency: Mismatch of budget allocation and use

The DOH budget and LGU Internal Revenue Allotments have been increasing in recent years. However, close analysis of the national and local budgets show that DOH spends less on Personnel Services than the LGUs where PS:MOOE ratios are 51:49 percent and 69:29 percent, respectively. Studies have shown that there may be underutilization of DOH appropriation cover, either because of poor absorptive capacity or problems with release of allotments. For instance, public health programs of DOH exhibited low utilization rates in 2004 and 2005 (Manasan, 2008) while in contrast, higher proportion of PS in LGU budgets resorted to less funding for health operations.

Although PhilHealth, as the main purchaser of health services limits its administrative expenses to only 12 percent of its budget, this is high compared to international standards. Moreover, limited coverage and low support value contribute to huge reserves that exceed the limits required by law.

The Steps Forward

Notwithstanding the gains that have been achieved in implementing the health financing reforms, the following strategies are recommended to carry on forward the goals of improving the health financing system:

1. **Increasing the resources for health**

   The DOH can advocate for higher and more resources for health by updating the Health Sector Expenditure Framework. Moreover, the DOH can use its subsidies to LGUs as a leverage to encourage more local investments for health through the Province-wide Investment Plans for Health. PhilHealth, on the other hand, can increase its premium through increased salary cap among the formally employed. It can also implement a tiered premium contribution structure among the IPP and increase the premium for SP and OWP members.

2. **Gearing towards Universal Coverage**

   To sustain membership to the Sponsored Program, the National Government can take full responsibility in securing funding for the enrollment of all indigent families. The LGUs, on the other hand, can facilitate the identification and enrollment of IPP members in their localities, with possible counterpart subsidy for their marginalized IPP members. Moreover, particular attention must also be given in enrolling the casual and contractual workers in the government and private sector, who are often uninsured because of the nature of their employment contract with their employers.

   Adopting a composite measure like Benefit Delivery Rate that will capture the different aspects of benefit delivery process (PhilHealth coverage; availment rate; and, support) can help track the program's progress towards achieving universal coverage.

3. **Defining the essential health packages and identifying who pays for what**

   Essential health care package at each level of care must be clearly defined and designed, including the source of financing (i.e. what should be subsidized by national government and LGU and what should be paid for by PhilHealth) and provider payment mechanism. This must also identify complementary health care package that may be offered by PhilHealth.

4. **Ensuring financial risk protection and cost containment by reforming provider payment mechanisms**

   This must include shifting from fee for service to case payment coupled with contracting with providers can limit balance billing and increase the support value of PhilHealth benefits.

5. **Promoting fiscal autonomy among health facilities**

   As accredited facilities, it must increase use of their revenues and income from PhilHealth reimbursementsto improve on their services and securing investments for capital outlays or ensuring the availability of appropriate medicines and supplies. At the national level, this can be achieved by pursuing corporate-like management of DOH-retained hospitals. And, at the local level, this can be achieved by promoting income retention for LGU hospitals and establishing the mechanisms as part of local health system accreditation.

6. Reforming the national and local budget.

Budget reform focus should be directed towards increased or secured allocations for priority public health programs, increased cost recovery mechanisms and reduced subsidies to retained hospitals and regulatory agencies. It must also be able to secure subsidies for premiums of the Indigent Program of PHIC. Moreover, the need to clarify roles of each funding source vis-a-vis the outputs to be purchased must be done.

At the local level, the value of performance-based grants to influence LGUs investments for local health system and improvements in delivery of health services must put more strengthened.

Editorial Board: Dir. Ma. Virginia G. Ala, Dir. Maylene M. Beltran / Technical Consultants: Mr. Lluis Vinyals / Editorial Staff: Ms. Rose G. Gonzales, Dr. Rosette Vergeire, Ms. Nita R. Valeza and Mr. Angelito L. Santiago / This health policy note was prepared by **Dr Leizel P. Lagrada**, Medical Officer VI/OIC Health Policy Division, Health Policy Development and Planning Bureau, Department of Health. Comments of Mr. Lluis Vinyals and Ms. Gitzi Diaz are gratefully acknowledged. The DOH also likes to acknowledge the support of the World Health Organization (WHO) in the publication of this policy brief.

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