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Expanding Social Health Insurance Coverage: New Issues and Challenges

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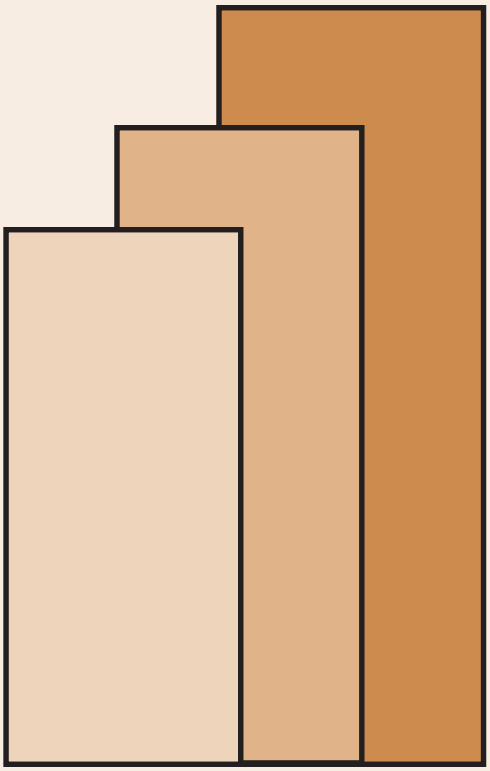

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EXPANDING SOCIAL HEALTH INSURANCE COVERAGE: NEW ISSUES AND CHALLENGES

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ABSTRACT

Highly unequal access to health services and the large share of household out-of-pocket spending in total health expenditures underscore the importance of attaining universal health coverage. This study evaluates the major challenges involved in moving toward universal coverage of the Philippine National Health Insurance Program. The strategic approach of PhilHealth in expanding population coverage has been described as "squeezing the middle": (i) "squeezing from the top" by expanding the PhilHealth coverage of the group subject to compulsory enrollment, i.e., the Employed Sector Program, (ii) "squeezing from the bottom" by expanding the coverage of the poor households under the Sponsored Program, and (iii) implementing interventions that are directed at expanding the coverage of non-poor households whose heads are employed in the informal sector under the Individually Paying Program.

Recently, government decided that the national government counterpart in the premium contributions of members enrolled in the Sponsored Program will only be available for families identified as poor under the National Household Targeting System for Poverty Reduction (NHTS-PR). This decision is anchored on the expectation that the use of the NHTS-PR will improve the targeting performance of the Sponsored Program largely by enabling the government to eliminate political intervention in the selection process.

While this new policy direction helps promote better targeting of the national government subsidy, it presents distinct challenges to the PhilHealth in moving towards universal coverage. First, ensuring the enrollment in the program of all the households identified under the NHTS-PR is a major hurdle considering that the selection and enrollment of Sponsored Program beneficiaries are largely initiated by the LGUs and considering the extent of political patronage involved in the process. Second, ensuring the continued enrollment in PhilHealth of some 5.1 million households who were enrolled in the Sponsored Program in 2010 but who are not in the NHTS-PR list of poor households even if they are no longer qualified for the national government subsidy is another major challenge.

The analysis suggests that broadening population coverage of social health insurance program may be difficult to achieve without concomitant reforms in other elements of the program, particularly the payment mechanism.

Keywords: PhilHealth, health expenditures, premium, health insurance, Sponsored Program, universal coverage, availment rate, National Household Targeting System for Poverty Reduction (NHTS-PR)

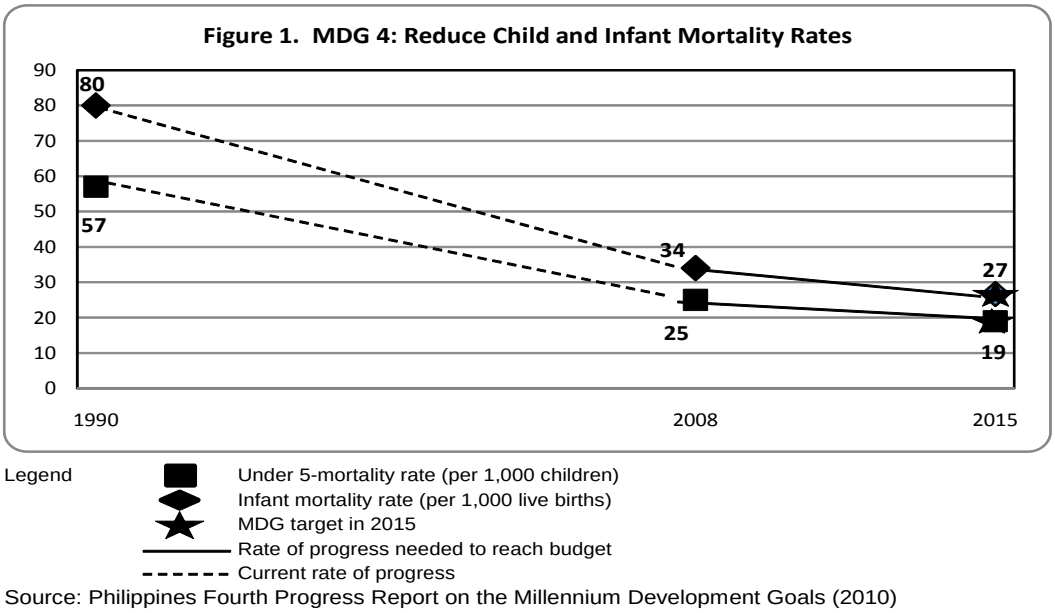
EXPANDING SOCIAL HEALTH INSURANCE COVERAGE: NEW ISSUES AND CHALLENGES

Rosario G. Manasan

1. BACKGROUND[1]

The Philippines posted notable gains in 1990-2006 in reducing both the infant mortality rate (IMR) and the under-5 mortality rate (U-5MR). During this period, the infant mortality was halved from 57 infant deaths per 1,000 live births in 1990 to 25 in 2008 (**Figure 1**). In like manner, the under-5 mortality rate went down from 80 to 34 under-five deaths per 1,000 children. In both cases, the rate of progress needed to reach the 2015 target is less than the actual rate of progress to date, suggesting that it is likely that the MDG targets for child health will be achieved.

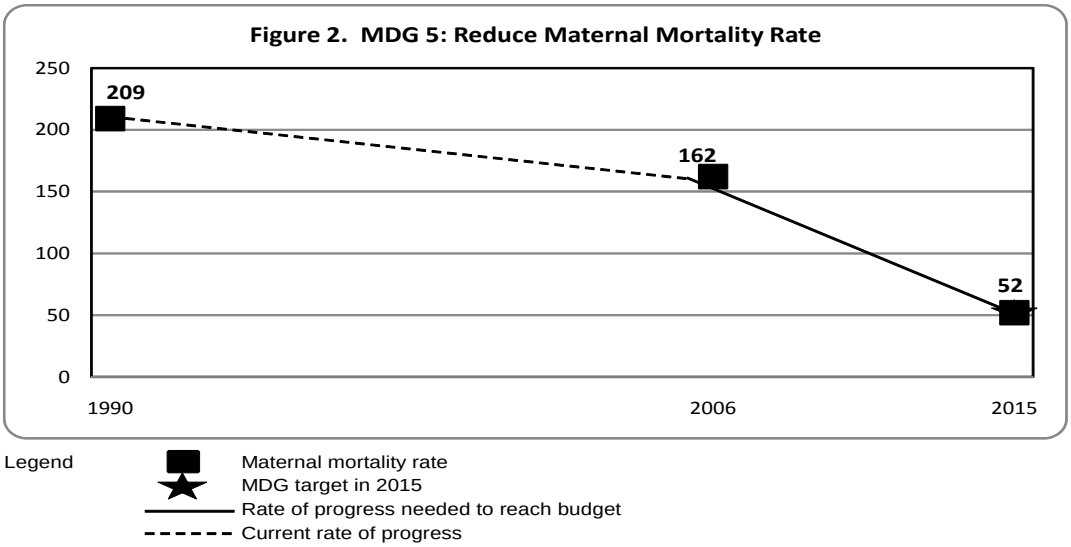
Figure 1. MDG 4: Reduce Child and Infant Mortality Rates



Source: Philippines Fourth Progress Report on the Millennium Development Goals (2010)

On the other hand, the country's performance in reducing the maternal mortality rate (MMR) is not as commendable, with the MMR declining from 209 maternal deaths per 100,000 live births in 1990 to 162 maternal deaths per 100,000 live births in 2006 (**Figure 2**). In other words, the rate of progress necessary to reach the 2015 target is more than 3 times higher than the actual rate of progress in 1990-2006, suggesting that the Philippines would have to reduce the MMR at a considerably faster pace than its historical performance to date. This indicates that the government would have to exert additional effort relative to what it has done in the past, if the Philippines were to attain the MDG target for maternal health.

[1] This subsection is drawn largely from Manasan (2010).



Source: Philippines Fourth Progress Report on the Millennium Development Goals (2010)

Moreover, the delivery of major public health services has stagnated, if not deteriorated in more recent years. For instance, the decline in recent years in the proportion of fully immunized children before they turn a year old may put the gains in child health at risk. To wit, the proportion of fully immunized children dipped from 87% in 2000 to 83% in 2006 (**Table 1**). At the same time, the proportion of children with diarrhea given ORS went down from 28% in 1998 to 14% in 2006. Also, the proportion of pneumonia cases among under-5 children given treatment was fairly stagnant at around 95%-96% in 1998-2006, although the indicator reached a high of 97% in 2003 and 100% in 2004.

Table 1.Selected Health Outputs Indicators, 1998-2006

	1998	1999	2000	2001	2002	2003	2004	2005	2006
% of pregnant women with 3 or more pre-natal visits	59.4%	65.6%	64.8%	62.9%	60.5%	64.3%	64.7%	62.3%	61.5%
% of pregnant women given tetanus toxoid vaccination at least twice	68.8%	59.4%	62.5%	54.2%	54.3%	59.6%	60.0%	58.8%	59.1%
% of lactating mothers given Vitamin A	49.1%	54.6%	57.0%	55.3%	52.9%	61.6%	53.2%	54.7%	59.3%
% of livebirths attended by medical professional		69.0%	69.0%	70.0%			68.7%	68%	70.0%
% of fully immunized children under 1	84.8%	87.9%	86.5%	81.7%	76.7%	83.7%	84.8%	83.7%	82.9%
% of infants given 3rd dose of Hepa B	37.3%	45.2%	6.2%	41.9%	38.5%	45.2%	45.6%	42.9%	72.9%
% of diarhhea cases amongst children under 5 given ORS	28.4%	25.9%	24.1%	22.4%	17.7%	17.8%	15.5%	14.2%	14.0%
% of pneumonia cases amongst children under 5 given treatment	94.7%	94.5%	93.9%	94.2%	94.7%	97.3%	99.9%	95.3%	96.0%
% of children under 1 given Vitamin A	72.8%	74.0%	76.9%	74.6%	74.7%	89.8%	79.2%	80.0%	81.0%
% of children between 1 and 5 given Vitamin A	89.6%	84.1%	101.3%	95.1%	94.1%	106.1%	111.1%	97.8%	95.7%
TB morbidity rate a/ b/	206.7	203.9	174.1	149.9	154.1	120.3	133.3	137.1	169.9
Malaria morbidity rate a/	96.8	91.8	66.6	39.1	50.3	36.5	24.9	43.3	27.6

* data shown for entire Philippines but data by province and city also available

a/ per 100,000 population

b/ respiratory plus other forms of TB

Source: Field Health Service Information System, various years

In contrast, the performance with respect to some of the key maternal care interventions has stagnated, if not deteriorated (**Table 1**). In particular, the proportion of pregnant women who had three or more pre-natal visits fluctuated around 61%-65% in 1999-2006. On the other hand, the proportion of pregnant women who received tetanus toxoid vaccination went down from 63% in 2000 to 54% in 2001-2002 before stagnating at 60%-61% in 2003-2006. Also, the proportion of births attended by a professional health provider was fairly flat at 68%-70% in 1999-2006.

Meanwhile, after being cut by about 45% from 90 to 50 per 100,000 population over the three-year period between 1999 and 2002, the decline in the incidence of malaria appears to have faltered, posting a reduction of 25% from 37 to 28 over the three-year period between 2003 and 2006 (**Table 1**). On the other hand, the incidence of tuberculosis went up from 120 per 100,000 population in 2003 to 170 per 100,000 population in 2006 after declining from 207 in 1998 to 154 in 2002.

Furthermore, inequitable access is evident for many of major public health services in 2003-2008. Thus, health outcomes for the poor are worse than those for their better-off counterparts. For instance, children from households in the lower wealth quintiles had higher rates of infant mortality and under-five mortality than children from higher wealth quintiles based on the 2003 and 2008 NDHS (**Table 2**). In addition, the poverty gap in the infant mortality rate and under-five mortality rate appears to have worsened between 2003 and 2008. In particular, the ratio of infant mortality rate of the poorest quintile to that of the richest quintile rose from 2.2 in 2003 to 2.7 in 2008. In like manner, the ratio of the under-five mortality rate of the poorest quintile to that of the richest quintile increased from 3.1 in 2003 to 3.5 in 2008.

Table 2. Early childhood mortality rates by wealth quintiles, 2003-2008

Wealth index quintile	Infant mortality	Under-five mortality
2008 NDHS		
Lowest	40	59
Second	29	38
Middle	24	32
Fourth	23	27
Highest	15	17
Total	25	34
2003 NDHS		
Lowest	42	66
Second	32	47
Middle	26	32
Fourth	22	26
Highest	19	21
Total	29	40

Source:2003 and 2008 NDHS

Also, households' access to various basic health services was highly disparate across income groups in 2003 and 2008. Lower income households continue to have poorer access to basic

health services than higher income households for a number of reasons, e.g., physical inaccessibility of facilities, financial constraints, or weak demand for health care. In addition, the poverty gap in households' access to some basic services (e.g., antenatal care and vaccinations) have widened over time.

The proportion of women who had a live birth five years preceding the NDHS did not get their antennal care from medical professionals declined from 7% in 2003 to 5% in 2008. At the same time, the proportion of pregnant women who did not receive any antenatal care also went down from 6% in 2003 to 4% in 2008 (**Table 3**). However, the proportion of women who did not get antenatal care from medical professionals plus the proportion of those who did not get any antenatal care at all is higher for women from less wealthy households than for women from the higher wealth quintiles. Also, the poverty gap (as measured by the ratio of the proportion of women from the poorest quintile who did not receive antenatal care from a medical professional to corresponding proportion for the wealthiest quintile) widened between 2003 (8.8) and 2008 (14.3).

Table 3. Provider of Antenatal Care, 2003-2008

Wealth index quintile	Doctor	Nurse/ midwife	Traditional birth attendant/ other	No one	Total
2008 NDHS					
Lowest	8.6	68.5	14.7	8.2	100.0
Second	24.0	67.4	4.5	4.1	100.0
Middle	39.6	56.3	1.5	2.6	100.0
Fourth	61.6	35.9	1.3	1.1	100.0
Highest	80.1	18.2	0.1	1.5	100.0
Total	39.1	52.0	5.2	3.8	100.0
2003 NDHS					
Lowest	8.6	63.8	16.2	11.2	100.0
Second	22.8	65.3	6.0	5.4	100.0
Middle	38.9	51.8	4.2	4.7	100.0
Fourth	58.5	37.7	1.5	2.1	100.0
Highest	79.9	16.7	1.0	2.1	100.0
Total	38.1	49.5	6.5	5.6	100.0

Source: 2003 and 2004 NDHS

Also, while the proportion of live births in the 5 years preceding the NDHS which were delivered in a health facility increased between 2003 (38%) and 2008 (44%), the proportion remains low (**Table 4**). Also, the proportion of live births delivered in health facility is lower for women from poorer households than relative those from better-off quintiles.

In like manner, the proportion of births in the 5 years preceding the NDHS which were assisted by skilled health providers tends to go up as the mother's wealth status goes up, suggesting that income is an important factor influencing the decision on place of delivery and birth attendant

(**Table 5**). On a positive note, the poverty gap in delivery in a health facility became narrower between 2003 and 2008 while the poverty gap in access to medical professional during delivery remained unchanged during these years.

Table 4. Place of delivery, 2003-2008

Wealth index quintile	Health facility		Home	Other/ missing	Total	Percentage delivered a health facility
	Public sector	Private sector				
2008 NDHS						
Lowest	11.5	1.5	86.8	0.2	100.0	13.0
Second	26.9	7.1	65.5	0.6	100.0	34.0
Middle	33.0	15.3	51.5	0.2	100.0	48.3
Fourth	39.0	29.7	30.9	0.4	100.0	68.7
Highest	29.4	54.5	15.8	0.2	100.0	83.9
Total	26.5	17.7	55.5	0.3	100.0	44.2
2003 NDHS						
Lowest	9.2	1.2	88.7	0.8	100.0	10.4
Second	20.4	4.4	74.3	0.8	100.0	24.8
Middle	32.2	11.1	56.2	0.4	100.0	43.3
Fourth	37.6	22.2	39.0	1.3	100.0	59.8
Highest	31.5	45.5	22.6	0.2	100.0	77.0
Total	24.2	13.7	61.4	0.7	100.0	37.9

Source: 2003 and 2004 NDHS

Table 5. Assistance during delivery, 2003-2008

Wealth index quintile	Doctor	Nurse	Midwife	Hilot	Relative/ other	No one	Don't know/ missing	Total
2008 NDHS								
Lowest	9.4	0.7	15.6	71.4	2.3	0.4	0.1	100.0
Second	24.4	2.1	29.1	42.8	1.3	0.2	0.2	100.0
Middle	34.5	2.4	38.9	23.7	0.4	0.0	0.2	100.0
Fourth	55.0	1.7	29.3	13.6	0.1	0.0	0.3	100.0
Highest	77.1	0.7	16.6	5.1	0.3	0.0	0.1	100.0
Total	35.0	1.5	25.7	36.4	1.1	0.2	0.2	100.0
2003 NDHS								
Lowest	8.6	0.5	16.0	68.9	4.9	0.4	0.7	100.0
Second	21.0	1.7	28.7	45.4	2.4	0.2	0.7	100.0
Middle	37.4	1.8	33.2	26.3	1.1	0.1	0.2	100.0
Fourth	52.6	0.6	31.2	13.3	1.4	0.0	0.9	100.0
Highest	73.2	1.2	18.0	7.0	0.6	0.0	0.1	100.1
Total	33.6	1.1	25.1	37.1	2.4	0.2	0.6	100.0

Source: 2003 and 2004 NDHS

Furthermore, 75% of mothers with children under five years of age reported having problems in accessing health care in the 2008 NDHS, just slightly lower than the corresponding proportion in the 2003 NDHS (**Table 6**). The most often cited problems include getting money for treatment (55%), concern no drug is available (47%), concern no provider is available (37%), distance to health facility (27%) and having to take transport to go to the facility (27%). As might be expected, these concerns appear to be more important for mothers from poorer households than those from better-off households.

A shift in the type of problems households have in accessing health care is evident between 2003 and 2008. While geographical access appears to be the biggest problem in 2003, the lack of financial protection from the costs associated with illness figured prominently among the concerns faced by households in accessing health care in 2008. For example, 55% of mothers cited "getting money for treatment" while 47% cited "concern that no drugs are available" as problems in accessing health care.

Table 6. Problems in accessing health care, 2003-2008

Wealth index quintile	Problems in accessing health care									
	Knowing where to go for treatment	Getting permission to go for treatment	Getting money for treatment	Distance to heatlh facility	Having to take transport	Not wanting to go alone	Concern no female provider available	Concern no provider available	Concern no drugs available	At least one problem accessing health care
2008 NDHS										
Lowest		16.1	74.0	57.8	56.1	31.8	29.6	54.0	71.0	92.3
Second		10.1	65.4	34.4	31.5	22.1	22.2	46.1	59.1	85.5
Middle		8.3	59.7	26.4	25.7	19.5	16.7	36.1	46.6	78.6
Fourth		5.2	48.4	17.2	17.3	16.5	12.9	32.9	40.2	69.0
Highest		5.2	38.2	12.9	12.8	13.8	10.1	23.4	30.0	57.2
Total		8.4	55.1	27.4	26.5	19.8	17.3	36.8	47.2	74.6
2003 NDHS										
Lowest	27.4	22.0	87.1	59.1	57.1	44.0	31.5			93.5
Second	19.2	12.7	80.1	33.8	32.5	28.8	20.9			87.1
Middle	13.6	8.4	73.0	22.2	20.3	25.2	18.0			80.8
Fourth	10.7	7.5	62.9	18.7	17.4	25.5	18.5			73.6
Highest	8.6	6.8	45.6	13.6	12.0	22.0	17.2			59.7
Total	14.9	10.7	67.4	27.2	25.6	28.1	20.5			77.1

Source: 2003 and 2008 NDHS

This development appears to be consistent with the high and increasing share of out-of-pocket (OOP) expense in the country's total health expenditure (THE) in 2000-2007. To wit, the share of OOP expense to total health expenditures surged from 41% in 2000 to 54% in 2007 (**Table 7**). This occurred as the increase in the share of social health insurance in total health expenditure failed to compensate for the contraction in share of general government spending in THE during the period. In particular, the share of social health insurance in THE increased only marginally

from 7% in 2000 to 9% in 2007 while the share of general government spending contracted dramatically from 41% to 26%. This trend is worrisome considering that countries with high out-of-pocket health expenditures tended to have a higher proportion of households facing catastrophic health expenditures (Xu et al. 2003).[2]

Table 7: Share in Total Health Expenditure by Financing Agents, 2000 – 2007 (%)

	2000	2001	2002	2003	2004	2005	2006	2007
Government	**40.6**	**36.2**	**31**	**31.1**	**30.7**	**29.4**	**26.6**	**26.3**
National	21.2	17.1	15.8	15.2	15.7	15.3	12.5	13
Local	19.3	19.1	15.2	15.9	15.0	14.1	14.1	13.3
Social Insurance	**7.0**	**7.9**	**9.0**	**9.1**	**9.6**	**9.7**	**8.8**	**8.6**
Philhealth	6.8	7.7	8.8	8.6	9.4	9.7	8.8	8.5
Employees' Compensation	0.2	0.2	0.2	0.5	0.3	0.0	0.0	0.1
Private Sources	**51.2**	**54.5**	**58.6**	**58.6**	**58.5**	**55.8**	**62.6**	**64.8**
of which:								
Out-of-Pocket	40.5	43.9	46.8	46.9	46.9	49.2	52.3	54.3
Private Insurance	2.0	2.5	2.9	2.3	2.5	2.1	1.8	1.8
HMOs	3.8	3.1	3.6	4.7	4.3	4.5	4.7	5.1
Employer-based Plans	3.7	3.9	4.1	3.4	3.6	2.9	2.7	2.5
Private Schools	1.1	1.2	1.3	1.3	1.2	1	1.1	1.1
Others	**1.3**	**1.3**	**1.4**	**1.2**	**1.2**	**1.1**	**2.1**	**0.4**
Memo item:								
Total Health Expenditure								
in billion pesos	114.9	116.6	117.2	148.6	165.3	198.4	216.4	234.3
% of GDP	3.4	3.2	3.0	3.4	3.4	3.6	3.6	3.5

Source: National Health Accounts, NSCB, various years

The highly unequal access to health services and the large share of household out-of-pocket spending in total health expenditures in the country underscore the importance of attaining universal health coverage. The objective of this short note is to evaluate the major challenges involved in moving toward universal coverage of the Philippine National Health Insurance Program. The analysis below suggests that broadening the population coverage of country's social health insurance program may be difficult to achieve without concomitant reforms in other elements of the program, particularly the payment mechanism.

2. PHILHEALTH: KEY FEATURES[3]

The National Health Insurance Act of 1995 (Republic Act 7875) created the Philippine Health Insurance Corporation (PhilHealth) which is tasked to administer the National Health Insurance Program (NHIP). The NHIP is envisioned to provide compulsory health insurance coverage for all as a mechanism that will allow all Filipinos to gain financial access to health services.

Membership. The PhilHealth took over the erstwhile Philippine Medical Care Commission (or Medicare) whose coverage was limited only to those with regular employment, i.e., members of

[2] Health spending is said to be catastrophic when a household must reduce its basic expenditure over a period of time to cope with health costs. In practice, health spending of at least 40% of a household's capacity of pay is deemed to be catastrophic where a household's capacity to pay is defined as effective income remaining after basic subsistence needs have been met.

[3] This section is drawn from Manasan (2009).

the SSS and the GSIS. In contrast, PhilHealth's membership may be partitioned into five groups: (i) the Employed Sector Program, (ii) the Overseas Workers Program, (iii) the Individually Paying Program, (iv) the Sponsored Program, and (v) the Non-paying Program. The Employed Sector Program of the PhilHealth calls for the compulsory coverage of all employees in government and the private sector, including household help and sea-based overseas Filipino workers. That is, all government and private employers are required to register their employees with the PhilHealth and to remit the premium contributions of their employees (including employer's share) to PhilHealth.

On the other hand, all land-based overseas Filipino workers who are registered with the Overseas Workers Welfare Administration (OWWA) are required to register under the Overseas Workers Program (OWP) of the PhilHealth and to pay the annual premium contribution to any PHIC office in the Philippines or abroad. Meanwhile, all self-employed persons, including professionals with their own practice, proprietors of businesses, actors/ actresses, directors, freelance writers and photographers, professional athletes, coaches, and trainers, personnel of civic and religious organizations and Philippine-based international organizations, farmers and fisherfolks, daily wage earners such as vendors, transport drivers and operators, and unemployed persons who are not qualified as indigents and parents who are not qualified as dependents *are encouraged* to register under the Individually Paying Program (IPP). Under this program, health insurance premiums are remitted voluntarily at any accredited payments centers on a quarterly, semi-annual or annual basis.

The Sponsored Program covers the poor or the indigent, i.e., individuals whose income is insufficient for the subsistence of their families. The Implementing Rules and Regulations of RA 7875 as amended by RA 9241 provide that the members of this program be identified on the basis of a means test using the data from a survey[4] conducted by the Social Welfare and Development Office of the LGU.

The Non-Paying Program covers (i) retirees and pensioners of the SSS and the GSIS prior the enactment of RA 7875 and (ii) PhilHealth members who are aged 60 years and over and who have paid at least 120 monthly contributions.

In addition to the principal member, the PhilHealth covers without additional premium the member's dependents, namely: his/ her legitimate spouse who is not a member in her/ his own right, children and stepchildren below 21 years of age, and parents or step-parents 60 years old and above who are not themselves members of PhilHealth. There is no limit to the number of dependents of each member.

Premium contributions. Under the Employed Sector Program, the monthly premiums (equal to 2.5% of the monthly salary base of the member) are shared equally by employees and their employers and are remitted to PhilHealth by the employer. The member's share in the monthly

[4] The survey aims to determine the socio-economic and health profile of the LGU. At present, the survey follows the so-called Community-Based Information System-Minimum Basic Needs (CBIS-MBN) approach but the Implementing Rules and Regulations of the RA 7875 as amended provides for the adoption of other means test mechanisms.

contribution is deducted and withheld automatically by the employer from the former's salary/ wage. It is then remitted to the PHIC together with the employer's share.

The minimum monthly salary base is set at PhP 4,000 while the maximum monthly salary base is PhP 30,000 effective January 2007. The maximum salary base was adjusted almost yearly since 2000 in order to allow a more equitable sharing of the contributions. Thus, the maximum monthly salary base rose consistently from PhP 5,500 in 2000, to PhP 7,500 in 2001, PhP 10,000 in 2002, PhP 15,000 in 2003, PhP 20,000 in 2005, PhP 25,000 in 2006.

In contrast, the premium for the Overseas Workers Program is uniformly set at PhP 900 per year for all members regardless of the member's capacity to pay. Prior to October 2010, the premium for the Individually Paying Program is also uniform at PhP 1,200 per year. However, starting in October 2010, the PhilHealth started to implement a two-tiered premium structure for members under the IPP. On the one hand, the premium for professionals earning at least PhP 25,000 monthly was raised to PhP 2,400 per year from PhP 1,200 per year[5] while that for other IPP members remained at PhP 1,200 per year. Note further that under both the OWP and IPP, the premium is shouldered in full by the member.

While the premium for the Sponsored Program is also set at PhP 1,200, it is fully subsidized by government and is paid for jointly by the national government, the province and municipality/ city where the indigent family resides. The national government and the LGU/s (both the province and the municipality/ city) share equally (50%-50%) in the case of LGUs belonging to first, second and third income classes. However, if the LGU belongs to the fourth, fifth or sixth income class, the LGU share rises gradually from 10% in the first and second years of enrollment to 50% in the tenth year. Conversely, the share of the national government in the premium subsidy for indigents residing in 4^{th}-6^{th} income class LGUs declines gradually from 90% in the first and second years of enrollment to 50% in the tenth year of enrollment.

The sharing between the province and the city/ municipality of the LGU share of the premium subsidy is variable. In some areas, the province pays for the entire LGU share. In others, the province and the city/ municipality divides the LGU share of the premium subsidy between them, with the exact sharing formula resulting from some negotiation between the two levels of local government.

Benefits. Principal members and their dependents, regardless of the membership program they belong to, are entitled to:

- in-patient care in accredited hospitals (including room and board, drugs and medicines, professional fees, laboratories and operating room) for confinements of not less than 24 hours;
- out-patient care (including day surgeries, dialysis and cancer treatment procedures such as chemotherapy and radiotherapy) in accredited hospitals and free-standing clinics;
- normal spontaneous deliveries up to the fourth one in accredited hospitals and birthing homes, maternity and lying-in clinics for a fixed case-payment of PhP 6,500 (inclusive of PhP 1,500 for pre-natal care);

[5] The premium for this group is programmed to increase to PhP 3,600 per year starting in October 2012.

- new born care package (including eye prophylaxis, umbilical cord care, Vitamin K, thermal care, administration of BCG vaccine and resuscitation of the new born, first dose of Hepatitis B immunization, and new born screening) from duly accredited hospitals and non-hospital facilities such as lying-in clinics, midwife-managed clinics, birthing homes, rural health units, ambulatory surgical clinics and other analogous health facilities for a maximum coverage of PhP 1,000;
- TB treatment of new cases of pulmonary and extra-pulmonary tuberculosis in children and adults through the Directly Observed Treatment Shortcourse or DOTS (including diagnostic work-up, consultation services and anti-TB drugs required in an outpatient set-up) in accredited TB-DOTS centers with a fixed case-payment of PhP 4,000;
- SARS and Avian Influenza package (including professional fees, hospital charges) for a coverage of PhP 50,000 per case for non-health worker members and their dependents and PhP 100,000 per case for forefront and high risk health care workers; and
- Influenza A (H1N1) package (including room and board, drugs and medicines, X-ray, laboratory and others, operating room, and professional fees) for a coverage of up to PhP 75,000 for non-health worker members and PhP 150,000 for health worker members.

In addition, indigent members and their dependents may avail of a *special* outpatient benefit package from accredited rural health units that includes: (i) preventive care - primary consultation, blood pressure monitoring, breast examination, rectal exam, body measurement, counseling for the cessation of smoking, and counseling for lifestyle change, (ii) diagnostic services - chest X-ray, sputum microscopy, and visual acetic acid screening for cervical cancer, and (iii) laboratory services - fecalysis, and complete blood count. On the other hand, OWP members and their dependents may avail of an *enhanced* outpatient benefit package that includes: (i) consultation services, (ii) wide ranging diagnostic services like complete blood count (CBC), routine urinalysis, fecalysis, fasting blood sugar, blood typing, hemoglobin/ hematocrit, electrocardiogram (ECG), anti-streptolysin O (ASO-Titer), hepatitis B screening test, treponema pallidum hemaglutination assay (TPHA), potassium hydroxide (KOH), erythrocyte sedimentation rate (ESR), pregnancy test, X-ray (skull, chest, lower and upper extremities), sputum microscopy, and pap smear, (iii) visual acuity examination; (iv) psychological evaluation and debriefing; (v) promotive/ preventive health services; (vi) auditory evaluation; and (vi) treatment of urinary tract infection (UTI), upper respiratory tract infection (URTI), and acute gastroenteritis (AGE).

PhilHealth in-patient care benefits provide “first-peso” coverage up to a maximum amount which is payable to providers on a fee-for-service basis. As such, PhilHealth pays the provider from the first peso of the bill up to the maximum benefit allowable while members are responsible for paying the remaining balance. The coverage cap varies with case type (surgical, general medicine, maternity, pediatrics, etc.) and level of the facility (primary, secondary, tertiary).

In contrast, PhilHealth uses capitation payments for the special outpatient care provided to indigent members. On the other hand, fixed case-payments are made for the TB DOTS, the Maternity package and the SARS and Avian Influenza package.

3. CHALLENGES IN MOVING TOWARDS UNIVERSAL COVERAGE

The strategic approach adopted by the PhilHealth in expanding coverage has been described as "squeezing the middle" (GTZ/ Jowett 2006). This approach segregates the population notionally into three groups based on their ability to pay the premium contributions to the PhilHealth: the top segment consists of households which are headed by those who are employed in the formal sector; the bottom segment consists of poor households whose premium contributions are subsidized by the government; and the middle segment consists of non-poor households headed by those who are employed in the informal sector. The strategy consists of (i) "squeezing from the top" by expanding the PhilHealth coverage of the group subject to compulsory enrollment, i.e., the Employed Sector Program, (ii) "squeezing from the bottom" by expanding the coverage of the poor households under the Sponsored Program, and (iii) implementing interventions that are directed at expanding the coverage of non-poor households whose heads are employed in the informal sector under the Individually Paying Program.

3.1. Situation Up to the End of 2010

Taken together, the contributory and non-contributory programs of PhilHealth have 70 million beneficiaries (consisting of both principal members and their dependents) in 2010. The total number of PhilHealth beneficiaries as a ratio of the total population went up from 59% in 2007 and 2008 to 72% in 2008 and 79% in 2010 (**Table 8**).

In 2010, the PhilHealth has 22.4 million registered principal members. The contributory program[6] has 15.9 million principal members, accounting for 71% of the total number of members, 67% of the total number of beneficiaries, 72% of total benefit payments and 93% of total premium contributions.

The Employed Sector Program comprises the bulk (44%) of the total membership of PhilHealth in 2010 while the Non-Paying Program has the smallest share in total membership (2%). On the other hand, the Individually Paying Program and the Overseas Workers Program contributed 17% and 10%, respectively, of total PhilHealth membership in 2010. The share of the Sponsored Program in total membership stood at 27% in 2010, up from 17% in 2007, with the doubling of the total number of Sponsored Program members during the period.

The coverage rate[7] of the contributory programs registered some improvement in 2007-2010 but it remains fairly low. To wit, the coverage of the contributory programs rose from 37% in 2008 to 41% in 2009 and 44% in 2010 (**Table 8**). Said improvement is largely on account of the Individually Paying Program and the Overseas Workers Program as the coverage rate of the Government Employed Sector Program and the Private Employed Sector Program has stagnated during this period. Nonetheless, the Employed Sector Program continues to have the highest

[6] The contributory program includes the employed sector program, overseas workers program and individually paying program.

[7] Here, the coverage rate is computed as the ratio of the number of registered principal members to the number of potential principal members based on the Labor Force Survey (LFS).

coverage rate. On the other hand, the coverage rate of the IPP and OWP combined remains to be the lowest. In contrast, the coverage rate of the Sponsored Program (reckoned relative to the estimated number of poor households[8]) has not only expanded significantly between 2007 and 2010, it has also exceeded 100% in 2009 and 2010.

Table 8. Number of members, premium contributions and benefit payments of PhilHealth, 2007-2010

	No. of members (in million)	% dist'n	Coverage rate as % of eligible members	No. of beneficiaries[a] (in million)	% dist'n
2010					
Government employees	1.9	8.7	64.5	6.6	9.4
Private employees	7.9	35.0	54.0	22.6	32.3
Sponsored indigents	6.0	26.9	154.1[b]	22.1	31.6
OWP	2.3	10.4		6.9	9.9
Individually paying members	3.7	16.7	32.9[c]	10.9	15.6
Non-paying members	0.5	2.2		0.9	1.2
Total	22.4	100.0	44.1[d]	70.0	100.0
2009					
Government employees	1.9	9.4	66.3	6.4	9.2
Private employees	7.0	34.7	50.7	20.2	29.6
Sponsored indigents	5.4	26.7	139.6[b]	19.7	31.7
OWP	2.1	10.4		6.2	10.7
Individually paying members	3.3	16.5	29.6[c]	9.7	17.8
Non-paying members	0.5	2.3		0.8	0.9
Total	20.2	100.0	40.9[d]	63.0	100.0
2008					
Government employees	1.9	11.3	67.3	6.3	11.3
Private employees	6.4	38.8	47.7	18.4	33.8
Sponsored indigents	3.3	19.8	85.4[b]	11.9	24.0
OWP	1.8	11.2		5.4	11.7
Individually paying members	2.7	16.5	24.8[c]	7.9	18.2
Non-paying members	0.4	2.4		0.7	1.0
Total	16.5	100.0	37.1[d]	50.6	100.0
2007					
Government employees	1.8	10.9	67.8	6.0	11.5
Private employees	7.0	42.8	55.1	20.1	38.6
Sponsored indigents	2.7	16.6	72.7[b]	10.0	21.2
OWP	1.6	9.7		4.7	10.7
Individually paying members	2.9	18.0	24.7[c]	8.6	17.2
Non-paying members	0.3	2.1		0.6	0.9
Total	16.4	100.0	39.5[d]	50.0	100.0

a/ beneficiaries refer to principal members and dependents; based on member-beneficiary ratio as computed in Benefit Delivery Rate study (DOH 2010)

b/ as % of poor households

c/ combined OFW and individually paying members

d/ refers to contributory program only and estimated relative to total number employed

Source: PhilHealth Corplan Group

[8] The number of poor households is based on the NSCB's revised estimates of poverty incidence for 2003-2009.

Government Employed Sector and Private Employed Sector. In 2010, there are 1.9 million principal members under the Government Employed Sector Program and 7.9 million principal members under the Private Employed Sector Program, accounting for 44% of total PhilHealth membership.

The coverage rate of the Government Employed Sector Program deteriorated from 68% in 2007 to 65% in 2010. On the other hand, the coverage rate of the Private Employed Sector Program fluctuated around 48%-55% in 2007-2010.

It is surprising that the coverage rates for the Employed Sector Programs are significantly lower than 100% considering the mandatory nature of said programs. This situation may be attributed to (i) the difference in the way that PhilHealth and the Labor Force Survey (LFS) of the National Statistics Office (NSO) defines formal employment in the government and private sector and (ii) non-compliance on the part of employers to the legal requirement to register their employees as PhilHealth members.

On the one hand, compulsory membership under the Employed Sector Program of PhilHealth is applicable only to individuals who have an employee-employer relationship with any government agency or private sector entity. Meanwhile, the classification of workers in the LFS is self-reported. As such, it is likely that some of those who report that they are government or private sector employees in the LFS are actually hired on a job-order basis in some government agency or as a contractual in some private sector enterprise.[9] Legally, the said individuals are not considered as employees but are more appropriately classified as self-employed. To the extent then that the LFS over-estimates the actual number of government and private sector employees, the estimates of the coverage rate in **Table 8** will tend to under-state the true coverage rates for the Employed Sector Programs and, conversely, tend to over-state that of the IPP and OWP.

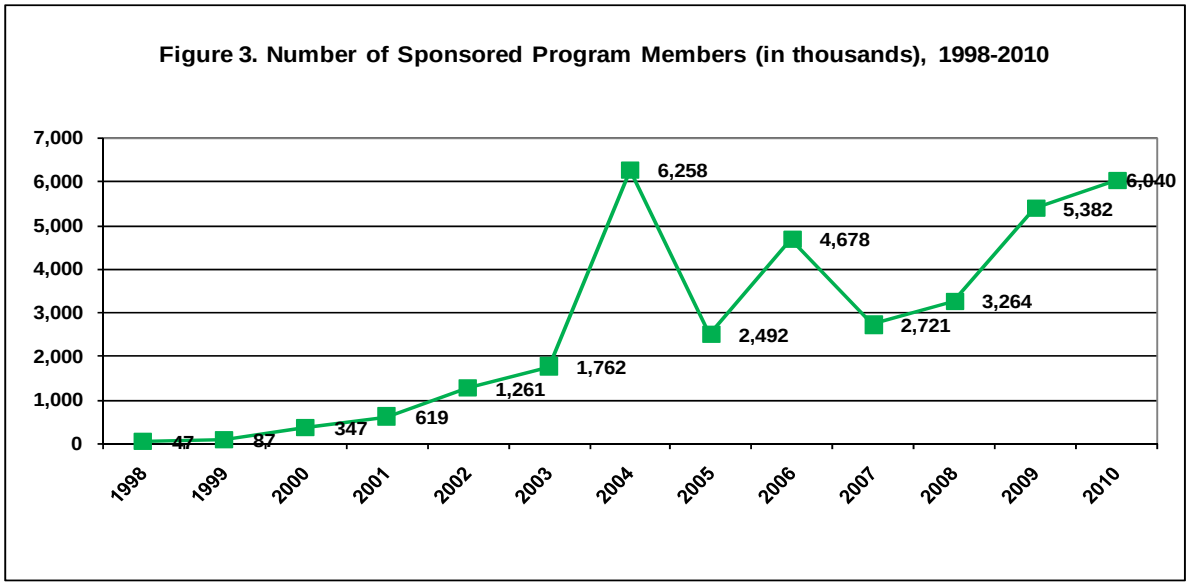
Beyond the measurement issue, the real problem with respect to the Employed Sector Program stems from the non-compliance of employers, especially small enterprises and single proprietorships, to the legal mandate for compulsory enrollment of their employees in PhilHealth. Unfortunately, there are no firm estimates of the extent of evasion. Various ways to minimize evasion in the PhilHealth Employed Sector Program have been proposed, including: (i) PhilHealth access to third party information from other government agencies like the SSS, GSIS and Pag-ibig to help enlarge the list of employees in the formal sector; and (ii) PhilHealth arranging to have LGUs require proof of payment of the PhilHealth contributions in behalf of their employees as a pre-condition to the issuance of business permits (GTZ/ Jowett 2006).

Sponsored Program. Enrollment in Sponsored Program fluctuated erratically in 2004-2006, after rising consistently from less than 350,000 in 2000 to 1.8 million in 2003 (**Figure 3**). Enrollment surged to 6.3 million families in 2004 due mainly to the Plan 5/25 launched by the Arroyo administration prior to the elections held that year. Plan 5/25 aimed to enroll five million families, or 25 million beneficiaries, under the Sponsored Program. In order to achieve this,

[9] Job-order "employees" are common in many local government units (LGUs) because of existing limitations on personal service expenditures. Likewise, the "contractualization" of employment is also widespread in the private sector. Contractualization is labor arrangement which replaces regular workers by temporary workers who are not considered employees, and, thus, are not entitled to the benefits given to employees.

funds were earmarked from the Philippine Charity Sweepstakes Office (PCSO) to pay the premium contributions of indigent members in full (i.e., without any LGU contribution).

When funding from the PCSO stopped, the number of sponsored families dropped to 2.5 million in 2006. Enrollment in the program swelled once again to 4.9 million in 2006 before declining to 2.7 million in 2007. Subsequently, an acceleration in the growth in the number of registered families in the Sponsored Program was evident.



Thus, the number of sponsored families rose to 3.3 million in 2008 and 5.4 million in 2009. As of the end of 2010, the Sponsored Program covered more than 6 million principal members accounting for 27 percent of the total membership, 22 percent of the total number of beneficiaries, 22 percent of the total benefit payments and 7 percent of total premium contributions (**Table 8**). The dramatic expansion in the number of members enrolled in the Sponsored Program may be attributed to the renewed ties with local chief executives (LCEs) and legislators as well as the participation of private organizations and big corporations which provide counterpart contribution in support of the indigent families (PhilHealth 2009). In particular, LGU-sponsored members represent almost 81 percent of the total sponsored membership.

As a result, the coverage rate of the Sponsored Program (reckoned relative to the estimated number of poor households as per the National Statistics Coordinating Board's revised estimate of poverty incidence for 2003-2009) went up from 73% in 2007 to 85% in 2008, 140% in 2009 and 154% in 2010. If the old set of estimates of poverty incidence (i.e., circa 2006) are used, the coverage rate of the Sponsored Program rose from 58% in 2007 to 70% in 2008, 115% in 2009 and 129% in 2010.

However, the mechanisms used to identify indigents under the Sponsored Program have been criticized by some analysts (e.g., Torregosa 2001 and Manasan 2009). Coverage rates in excess of 100% are an indication of poor targeting under the Sponsored Program. Manasan (2009) report that, in 2007-2009, 23 to 44 provinces have enrolled beneficiaries in excess of the actual

number of poor households in their jurisdiction based on the 2006 Family Income and Expenditure Survey (FIES). The "excess" enrollment in these provinces is estimated to account for 57 percent to 64 percent of the actual number of poor households in said provinces on the average. In 2010, 56 provinces have enrolled more beneficiaries than expected based on the 2006 FIES. The "excess" enrollment in these provinces accounts for 73 percent of the actual number of poor households in the said provinces.

But even more telling, only 912,696 households or 21% of the households which are identified as poor under the National Household Targeting System for Poverty Reduction (NHTS-PR) are covered under the Sponsored Program in 2010 (PhilHealth Board Resolution No. 1478 s. 2011). Conversely, only 15% of the 6 million households enrolled under the Sponsored Program in 2010 are considered poor under the NHTS-PR.

Poor targeting under the Sponsored Program stems from the absence of (or the non-adherence to) a good targeting protocol at the local level. The Implementing Rules and Regulations (IRR) of RA 7875 as amended by RA 9241 provide that the beneficiaries of this program will be identified on the basis of a means test using the data from the Community-Based Information System-Minimum Basic Needs (CBIS-MBN) but emphasized that the PHIC reserves the right to adopt other means test mechanism that it may deem appropriate. RA 7875 also provides that the conduct of the means test will be undertaken by the Barangay Captain in coordination with the Social Welfare Officer of the LGU under the supervision of the Local Health Insurance Office of the PhilHealth.

However, interviews with some barangay officials indicate that the selection process is *ad hoc* even in areas where the Community-Based Monitoring System (CBMS) is currently in place. These interviews also suggest that the selection of Sponsored Program beneficiaries in many LGUs prior to 2011 was highly politicized and as such was susceptible to local patronage politics.

Individually Paying Program and the Overseas Workers Program. In 2010, there are 3.7 million principal members under the Individually Paying Program and 2.3 million principal members under the Overseas Workers Program (**Table 8**). The coverage rate of the Individually Paying Program is the lowest among all the programs of PhilHealth, reflecting the unique difficulties in enrolling and collecting premium contributions from informal sector workers. However, some gains in expanding coverage of these two programs have been made in recent years. Thus, the number of principal members covered under Individually Paying Program and the Overseas Workers Program combined represents 33% of the informal sector workers in 2010, up from 25% in 2007-2008 and 30% in 2009.[10]

With the informal sector accounting for more than 50% of the labor force, the importance of expanding the coverage of the informal sector under the IPP cannot be over-emphasized. Moreover, not only is the coverage of the IPP low, it is reported that about two-thirds of IPP members are not paying their premiums on a regular basis because informal sector workers tend to have uncertain and variable income through the year (Jowett and Hsia 2005).

[10] For our purposes here, the informal sector workers includes the own account workers, unpaid family workers, wage workers in private households and wage workers in family-owned business.

To broaden the coverage of the IPP, PhilHealth launched the "Kalusugan Sigurado at Abot Kaya sa PhilHealth Insurance" or (KASAPI) in August 2005. Under KASAPI, PhilHealth enters into strategic partnerships with organized groups (OGs) such as microfinance institutions, cooperatives, rural banks and NGOs, many of which specifically serve workers in the informal economy. Under KASAPI, these OGs act as marketing and collection agents for PhilHealth. In exchange, the KASAPI offers the MFIs an incentive (in the form of a discount on the premium contributions due) if they enroll at least 70% of their eligible members under the IPP. The discount increases as the size of the group increases and as the percentage of eligible members enrolled increases. The MFIs then has the option to either pass on the discount, in part or in full, to their members or to use the discount to provide other services to their members. The use of the OGs as collection agents allows members of the OGs greater flexibility in timing the payment of their premiums, and possibly lower premiums and/ or more services from their OGs.

However, the success of the KASAPI has been fairly limited. Out of the 600,000 members of 14 OGs working with the KASAPI program (Asanza 2007), the program enrolled 23,332 informal sector families as of December 2008, up from an initial enrollment of 1,863 in 2006. The PhilHealth faces serious challenges in its effort to expand the coverage of the IPP using the KASAPI model. Many organized groups like worker's associations and smaller cooperatives have less than 1,000 members and, as such, do not meet one of the criteria to qualify under the KASAPI (Schmidt et al. 2005). Thus, there is a need to develop a strategy to more effectively reach the members of these smaller OGs and, more importantly, the unorganized informal sector. In an earlier effort by PhilHealth to partner with smaller OGs, the drop out rate of OG members was found to be high (75% to 85%), only slightly lower than the figure of about 91% for informal worker enrollees prior to the implementation of the initiative (Basa 2005).

3.2. Recent Developments and Present Challenges

With the establishment of the National Household Targeting System for Poverty Reduction (NHTS-PR), government decided that the national government counterpart in the premium contributions of members enrolled in the SP will only be available for families identified as poor under the NHTS-PR. This decision is anchored on the expectation that the use of the NHTS-PR will improve the targeting performance of the Sponsored Program largely by enabling the government to eliminate political intervention in the selection process.

While it helps promote better targeting of the national government subsidy, this new policy direction presents distinct challenges to the PhilHealth in moving towards universal coverage. First, ensuring the enrollment in the program of all the households identified under the NHTS-PR is a major hurdle considering that the selection and enrollment of Sponsored Program beneficiaries are largely initiated by the LGUs and considering the extent of political patronage involved in the process. Second, ensuring the continued enrollment in PhilHealth of some 5.1 million households who were enrolled in the Sponsored Program in 2010 but who are not in the NHTS-PR list of poor households even if they are no longer qualified for the national government subsidy is another major challenge.

To address the first problem, government decided that the premium contribution of all families identified as poor under the NHTS-PR will be shouldered 100% by the national government (PhilHealth Board Resolution No. 1478 s. 2011). However, an amendment of RA 7875 might be needed to put this decision into effect. Note that RA 7875 provides that the "national government shall provide up to 90% of the subsidy for indigents."

This move is meant to achieve three things and appears to be well justified. First, it is expected to eliminate the political economy issues and consequent high leakage associated with the present practice of LGUs identifying the beneficiaries under Sponsored Program. Second, considering the positive and statistically significant relationship between the coverage rate of the Sponsored Program and per capita LGU own-source revenue (Manasan and Cuenca 2011), it is expected to improve the coverage of indigent families even in areas where the fiscal capacity of the LGU is low.[11] Third, it is also meant to help ensure greater stability in the enrollment of indigent families as the national government no longer has to wait for the LGUs to initiate the selection and enrollment process. Thus, funding of the government subsidy for the premium contributions is expected to be better secured.

The 2011 State of the Nation Address Technical Report avers that all of the 5.2 million households identified as poor by the NHTS-PR have been enrolled in the PhilHealth Sponsored Program as of July 19, 2011. However, in a roundtable discussion organized by the House of Representatives Committee on Poverty last July 27, 2011, the issue of cross-checking/ validating PhilHealth beneficiaries vis-à-vis the NHTS-PR list was still raised.

To address the second challenge presented by the use of the NHTS-PR in identifying beneficiaries of the Sponsored Program, the PhilHealth Board decided to allow LGUs and other sponsors to renew the membership for 2011 of those families who were enrolled in the Sponsored Program in 2010 even if they are not in the NHTS-PR list of poor families at the existing LGU counterpart contribution rate and for PhilHealth itself to shoulder what used to be the national government counterpart of the premium contribution (PhilHealth Board Resolution No. 1478 s. 2011). PBR No. 1478 s. 2001 has the effect of providing government subsidy (albeit from the PhilHealth) for the premium contribution of non-poor informal sector workers. But perhaps what is even more problematic, this move will tend to have a dis-incentive effect on those who are currently enrolled and contributing to the Individually Paying Program.

The incremental fiscal cost to the national government of PhilHealth Board Resolution 1478 for the Sponsored Program is PhP 5.2 billion (equal to the PhP 12.5 billion that represents 100% NG subsidy for the NHTS-PR poor less the PhP 7.3 billion that would have been used to fund the NG counterpart for the premium contribution of the 6 billion members under the Sponsored Program in 2010).[12] In addition, the cost to PhilHealth of subsidizing the premium contribution of the non-poor informal sector workers who used to be enrolled as SP members is PhP 6.2 billion. This cost could go up by another PhP 3.3 billion if the PhilHealth subsidy is extended to

[11] However, a similar relationship between the coverage rate and per capita IRA is not established from the data.

[12] These estimates are computed based on the revised annual premium of PhP 2,400 per family enrolled in the Sponsored Program.

those who are enrolled in the Individually Paying Program. It is not clear if said arrangement is sustainable for the PhilHealth in the medium term.

The discussion above highlights the tension between fiscal sustainability and broader coverage of the informal sector. Given this perspective, there is a need to revisit and redefine the PhilHealth-LGU engagement. One possibility is to treat LGUs in much the same way that organized groups like microfinance institutions, cooperatives, and NGOs are treated under the PhilHealth KASAPI program. In this regard, LGUs may be viewed as a consolidator of informal sector workers wishing to enroll under the Individually Paying Program.[13] LGUs will collect the premium contributions of the non-poor informal sector workers and remit the same to PhilHealth. LGUs may be given the option to co-share the premium contribution with the enrolled members. There is anecdotal evidence that such arrangements are actually in effect in many LGUs even in 2010 and prior years. However, there might be a need to phase in the implied increase in premium contributions of these enrolled members.

As an incentive to LGUs, they may not only be given a discount on the premium contributions due (as is the case with other organized groups) but the health facilities they operate may also receive capitation payments on account of the families they enroll under the Individually Paying Program. This implies that the special outpatient benefits being to the Sponsored Program will also be extended to the Individually Paying Program.

4. MULTIDIMENSIONAL ASPECT OF UNIVERSAL COVERAGE

Universal coverage may be defined as physical and financial access by all persons in society to the full range of personal and non-personal health services they need at affordable cost. This definition of universal coverage "implies equity in access and financial risk protection" (WHO 2005). To achieve universal coverage, it is critical that the pre-paid contributions that are collected on the basis of ability to pay are pooled and the funds used "to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditures (WHO 2008).

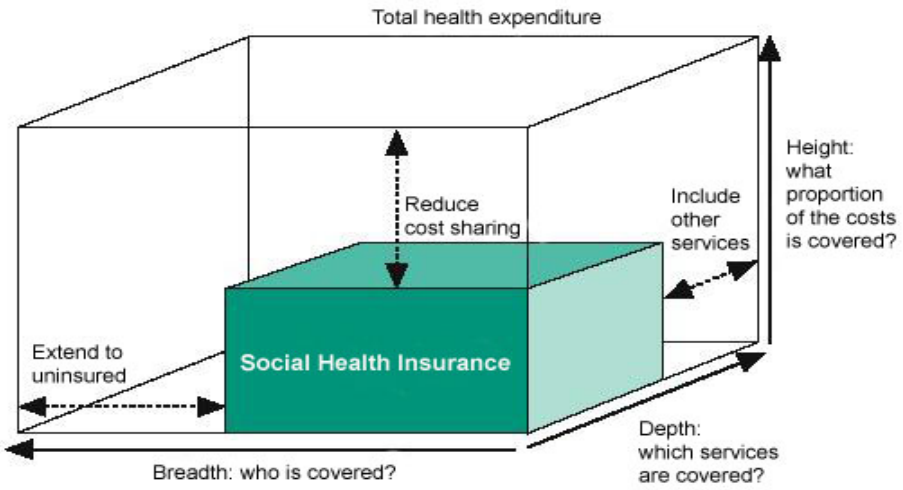
Universal coverage may be thought of as having three dimensions (see **Figure 4**):

- *breadth of coverage* or population coverage refers to the proportion of the population that enjoys social health protection;
- *height of coverage* or financial risk protection refers to the portion of health-care costs that are covered under the social health insurance program; and
- *depth of coverage* or service coverage refers to the range of services that are available from the system (WHO 2008; WHO 2010).

The aforementioned framework is useful in better understanding the challenges in attaining universal coverage under the PhilHealth. The analysis below shows that population coverage is not entirely independent of the proportion of health care costs that is covered by Philhealth nor the health services which are covered.

[13] This proposal is consistent with the discussions during a small group meeting with PhilHealth relative to the formulation of the Medium-Term Development Plan last May 2011 where the need to work with LGUs in paying the premium of the informal sector was pointed out.

Figure 4. Three ways of moving towards universal coverage



Adapted from The World Health Report 2008

4.1. Height of Coverage or Financial Risk Protection

The discussion below underscores the fact that the population coverage is not independent of the financial risk protection that social health insurance affords its members.

Availment rate. DOH (2010) estimates the availment rate[14] for the regular benefit package of PhilHealth for the Sponsored Program to be equal to 33% while that for the Non-Sponsored Program to be equal to 42% (**Table 9**). The availment rate is influenced by the availability of accredited providers (facilities as well as health care workers). DOH (2010) documents the large disparity in the accessibility of accredited providers across geographic areas. For instance, the said study reports 25 provinces (e.g., those in ARMM and CAR) have no access to tertiary facilities based on the 2008 list of accredited facilities of the PhilHealth.

Table 9. Availment rate and support value, by program, 2008

	Adjusted Availment Rate	Support Value
Sponsored program	33%	50%
Non-sponsored program	42%	28%
All programs	42%	34%

Source: DOH 2010

Also, there is a shortage in the number of health workers in many LGUs, especially those in rural areas, partly because of the restrictions on LGU spending on personal services under the Local

[14] The availment rate is the ratio of the number of members who availed of covered services in PhilHealth accredited facilities to the total number of enrolled members who are eligible to file claims.

Government Code. The problem may also be attributed to the lack of incentives for health workers in geographically isolated and disadvantage areas.

Moreover, the shortage of drugs and supplies in certain hospitals, particularly in public facilities, is found to be commonplace (Solutions Inc. 2009). Such shortages tend to discourage members, particularly indigent members, from availing of health care services. For instance, patients have to buy medicines, drugs and supplies they need from pharmacies outside the health facilities when these are not available in the said facilities. Although the cost of the medicines, drugs and supplies may be reimbursed (up to a limit), PhilHealth members have to bear the cost of money due to advancing payment for the drugs, medicines and supplies, at the very least.[15] Moreover, the filing of reimbursement claims is tedious and time-consuming. Thus, the effective financial support value provided by PhilHealth is eroded (Solutions Inc. 2009).

Another barrier to the availment of PhilHealth benefits stems from the inability of many registered members (particularly those under the Sponsored Program) to submit documentary requirements like birth certificates of children and marriage certificates of spouses that serve as proof of dependence. Many poor families in rural areas do not have these documentary requirements. While late registration of births is possible and the procedures to do so have been streamlined, it is said that families who typically encounter this problem sometimes cannot afford the fees and other attendant cost that are associated with late registration of births.

Support value. The support ratio[16] for the regular benefit package is estimated to be equal to 50% for the Sponsored Program while that for the Non-Sponsored Program is estimated to be equal to 28% (DOH 2010). The higher support value for the Sponsored Program relative to that of the Non-Sponsored Program is attributed by the DOH (2010) to the fact that the poor tended "to use public facilities that continue to be heavily subsidized."

Manasan (2009) notes that:

> "The observed low support value of PhilHealth may also be attributed to (i) the "first peso coverage up to a cap" approach that is followed in the provision of benefits, (ii) paying providers on the basis of fee-for-service, and (iii) the absence of regulations on the fees that providers charge (Gertler and Solon 2002, Jowett and Hsiao 2005, Kwon 2005). Under this setup, the protection provided members may not increase even if the benefit ceiling were adjusted upward. This is so because health care providers are able to capture insurance benefits by raising the prices they charge insured patients (Gertler and Solon 2002). In a sense, there is a ceiling on the maximum risk that PhilHealth will bear but there is no limit on the risk that its members are exposed to (Kwon 2005). In turn, the large out-of-pocket expenditures that households have to shoulder even when they are

[15] A patient exit survey of public hospitals in the Visayas in 2005 shows that the hospital bill accounts for 72% of total medical expenses, with the remaining 28% accounted for purchases of drugs and medicines outside the hospital.

[16] The support ratio is the ratio of PhilHealth benefit payments to the actual expenditures of eligible PhilHealth members who actually availed of covered services.

> insured may help explain the low availment rate, especially for the Sponsored Program. …
>
> As such, the low financial protection provided by PhilHealth benefits may also have some negative impact on expanding population coverage as it discourages prospective members from joining PhilHealth (under the Individually Paying Program). At the same time, it tends to exacerbate adverse selection, with the danger that lower risk individuals will elect not to join the program (Jowett and Hsiao 2005).
>
> The solution to this problem appears clear cut: (i) introduction of cost sharing mechanisms like deductibles and coinsurance to minimize moral hazard, (ii) shifting of the payment system from fee-for-service to a mix of capitation and case-payments, and (iii) ban on balance billing (Kwon 2005)."

The PhilHealth has taken steps towards these reforms. PhilHealth has started to put into effect no-balance billing for members under the Sponsored Program provided they are confined in a public health facility for 22 medical and surgical cases consisting of 11 medical conditions (dengue I and II, moderate risk and high risk pneumonias, hypertension, cerebrovascular accident I and II, diarrhea, typhoid fever and asthma, asthma and neonatal care package) and 11 surgical procedures (caesarean section, dilation and curettage, hysterectomy, mastectomy, appendectomy, cholecystectomy, herniorrhaphy, thyroidectomy, radiotherapy, hemodialysis, and normal spontaneous delivery).

However, it still remains to be seen how effective this move will be in reducing the out-of-pocket expenditures of poor households considering that the shortage of drugs and medicines is a recurring problem in many public health facilities. Also, this initiative will provide little incentive to non-poor households, particularly those whose heads are employed in the informal sector to voluntarily enroll in the PhilHealth, unless and until it is expanded to cover the Individually Paying, the Overseas Workers and the Employed Sector Programs.

4.2. Depth of Coverage or Service Coverage

The services covered by PhilHealth are heavily skewed in favor of in-patient services. Outpatient consultation and routine diagnostic services are covered only for members enrolled in the Overseas Workers Program and the Sponsored Program but not for those under the Employed Sector Programs and the Individually Paying Program. However, TB DOTS, selected day surgeries, chemotherapy, radiotherapy, and dialysis are available to all members and beneficiaries of PhilHealth.

From the perspective of equity, outpatient consultation and routine diagnostic services should be made available to all members. Also, given that drugs and medicines account for roughly 50% of total out-of-pocket health expenditures of households, the exclusion of drugs and medicines from the outpatient benefit package needs to be revisited. Schwefel (2009) point out failure to use medicines when they are needed can lead to preventable morbidity and mortality, catastrophic episodes of illness that increase impoverishment, and large-scale losses to health systems and employers. In this regard, insurance programs that cover medicines can play a key role in

extending access to high risk populations and in encouraging more economical and effective use of medicines.

5. CONCLUSION AND RECOMMENDATIONS

Coverage of the Employed Sector Programs. To expand the population coverage of the Employed Sector Program, there is a need to improve compliance of employers, especially small enterprises and single proprietorships, to the legal mandate for compulsory enrollment of their employees in PhilHealth. To enhance PhilHealth enforcement activities in this regard, there is need for PhilHealth access to third party information from other government agencies like the SSS, GSIS and Pag-ibig to help enlarge their list of employees in the formal sector. Also, arrangements to have LGUs require proof of payment of the PhilHealth contributions in behalf of their employees as a pre-condition to the issuance of business permits will be helpful (GTZ/ Jowett 2006).

Improving coverage of and improving targeting of the poor. This paper supports the use the NHTS-PR in identifying poor families that will be enrolled under the Sponsored Program. It also supports the move to have the national government to fully subsidize the premium contributions of the poor families enrolled in the Sponsored program. This initiative is well justified on the following grounds. First, it will minimize political interference in the selection of beneficiaries and reduce leakage. Second, it will likely improve the coverage of indigent families even in areas where the fiscal capacity of the LGU is weak. Third, it will help ensure greater stability in the enrollment of indigent families as funding of the government subsidy for the premium contributions is better secured.

New challenges in expanding coverage of the informal sector. There is a need to revisit PhilHealth's proposal to allow LGUs and other sponsors to renew the membership for 2011 of those families who were enrolled in the Sponsored Program in 2010 even if they are not in the NHTS-PR list of poor families at the existing LGU counterpart contribution rate and for PhilHealth itself to shoulder what used to be the national government counterpart of the premium contribution. It has the effect of providing government subsidy for the premium contribution of non-poor informal sector workers, ostensibly because this group belongs to quintile 2 even if the said group is likely to be poorly targeted. Moreover, this move will also tend to have a dis-incentive effect on those who are currently enrolled and contributing to the Individually Paying Program.

Given this perspective, there is a need to redefine PhilHealth-LGU engagement. This paper proposes that the possibility of treating LGUs in much the same way that organized groups like microfinance institutions, cooperatives, and NGOs are treated under the PhilHealth KASAPI program be explored. In this regard, LGUs may be viewed as a consolidator of informal sector workers wishing to enroll under the Individually Paying Program. LGUs will collect the premium contributions of the non-poor informal sector workers and remit the same to PhilHealth. LGUs may be given the option to co-share the premium contribution with the enrolled members. However, there might be a need to phase in the implied increase in premium contributions of these enrolled members.

As an incentive to LGUs, they will not only be given a discount on the premium contributions due (as is the case with other organized groups) but the health facilities they operate will also receive capitation payments on account of the families they enroll under the Individually Paying Program. This implies that the special outpatient benefits being to the Sponsored Program will also be extended to the Individually Paying Program.

Need to improve availment rate and support ratio. Improving compliance of the Employed Sector Programs and expanding the coverage of the informal sector under the Individually Paying Program will not be possible if the availment rate and the support ratio are not increased.

To improve the availment rate, there is a need to upgrade the facilities of public hospitals, RHUs and BHSs so as to increase the number of accredited public health facilities. The Health Facilities Enhancement Program is aimed at achieving this. However, there is need to accelerate its implementation.

To increase the PhilHealth support ratio, there is a need to (i) introduce cost sharing mechanisms like deductibles and coinsurance to minimize moral hazard, (ii) shift the payment system from fee-for-service to a mix of capitation and case-payments, and (iii) ban on balance billing. These changes should be made available not just for the Sponsored Program but for the other programs as well.

Need to improve service coverage. To achieve equity across programs, outpatient consultation and routine diagnostic services should be made available to all members. Also, given that drugs and medicines account for roughly 50% of total out-of-pocket health expenditures of households, the exclusion of drugs and medicines from the outpatient benefit package needs to be revisited.

Sequencing issues. Given the interdependence of population coverage, financial risk coverage and service coverage, government has to pay close attention to sequencing issues and the need to guard against perverse consequences.

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